

Responding to Client Questions: Perceived Impact of Therapist Responses

Natalie M. Grandy

The University of Akron

Author Note

Natalie M. Grandy, Department of Psychology, The University of Akron

Correspondence concerning this paper should be addressed to Natalie M. Grandy,  
Department of Psychology, The University of Akron, Akron, Ohio 44325-4301. E-mail:  
nmg35@zip.s.uakron.edu

### Abstract

Considerations for responding to clients' questions have been largely neglected in psychological literature, training, and supervision. Based on clinical and supervisory experience, Edelstein and Waehler (2011) developed a set of four guidelines designed to assist therapists in responding to client questions. The guidelines are: 1) receive the question respectfully, 2) promote the client's curiosity about the question, 3) answer the question sufficiently, and 4) explore possible underlying or idiosyncratic meanings of the question. These four guidelines are intended to produce three specific therapeutic gains: 1) clients' enhanced breadth of material explored, 2) clients' enhanced depth of material explored, and 3) increased client-therapist connectedness. The purpose of this study was to identify theoretical and empirical support for the utility of Edelstein and Waehler's guidelines in producing the desired outcomes. Participants (N=138) rated videos of mock therapy sessions in which a therapist responded to a client's question in different ways: 1) using Edelstein and Waehler's guidelines, 2) answering the client's question through psychoeducation, and 3) reflecting the question back to the client. Participants rated the sessions on measures of the client's breadth of material explored, depth of material explored, client therapist connectedness, and therapist competence. Between-subjects, one-way MANOVA data analyses revealed non-significant results when analyzing the impact of the different therapist responses. Limitations, implications, and recommendations for future studies are discussed.

## Responding to Client Questions: Perceived Impact of Therapist Responses Utilizing New Guidelines

“How should I respond when my client asks me a question?” is a familiar wondering that can make even seasoned mental health professionals unsure about their actions (Chakraborti, 2006; Edelstein & Waehler, 2011; Feldman, 2002; Glickauf-Hughes & Chance, 1995).

However, the issue of responding to client questions in a way that will promote client growth has received little attention in the mental health literature (Brodsky, 2011; Kemp, 2004; Feldman, 2002; Glickauf-Hughes & Chance, 1995) and training (Edelstein & Waehler). Although even experienced mental health professionals can feel ill-prepared when faced with certain client-questions (e.g. Chakraborti, 2006), novice mental health professionals in particular, who have not yet had experiences which develop a sturdy skill-base for client-therapist interactions, are especially susceptible to the feeling of being “caught off-guard” in response to clients’ direct questions (Edelstein & Waehler). Edelstein and Waehler note seven reasons why client questions often cause apprehension for therapists, stating that such questions may: 1) represent a shift away from the normal therapeutic pattern in which the therapist asks the questions, 2) reflect varying motives, 3) cause the therapist to experience an uncomfortable level of responsibility inherent in answering client questions, 4) make the therapist realize that he/she cannot always provide adequate answers, 5) bring the focus of the therapy session away from the client and onto the therapist, 6) highlight the nonclient, nontherapist relationship, and 7) disrupt the client-therapist relationship.

Adding to the complexity of responding to clients’ questions is the wide variety of questions that clients might ask. For example, questions about the practicalities of the therapeutic process (i.e. “How long do sessions typically last?” “Do you have a sliding scale?”) might

require a direct response from clinicians, while questions about the therapist (i.e. “Are you married?” “What is your religion?”) may or may not be answered directly depending on the therapist’s personal style or therapeutic orientation. Furthermore, questions about therapeutic progress (i.e. “Do you think I’ll get better?” “How long will it take for me to feel better?”), and questions about the cause of clients’ struggles (i.e. “Why do I feel so sad all the time?” “Do you think I feel so lousy because of my parents?”) might require exploration by the therapist into the origins of the wondering. Thus, different therapist responses may be necessary depending on the typology of the client’s question. Decisions regarding the most appropriate ways to respond to specific types of questions may cause therapists additional anxiety.

To date, there is no extant typology to organize client questions. Edelstein and Waehler (2011) organize their discussion of client questions by question topic (i.e., “Confidentiality,” “Boundaries,” “Sexuality”), while other theorists (i.e. Glickauf-Hughes & Chance [1995]) categorized client questions by underlying motives. Still, other theorists categorize client questions by more arbitrary typologies. For example, Feldman (2002) suggested that there are four typologies of client questions: 1. Questions about availability; 2. Questions about therapist competence; 3. Personal questions about the therapist; 4. Questions about treatment. This lack of unity in defining question typologies may be one reason for the dearth of research and training in best practices for responding to client questions.

Further challenging clinicians confidence in responding to client questions, Feldman (2002) noted that the initial phases of therapy pose particular challenges in answering client questions for four reasons: the therapist can feel “put on the spot;” there is often little information to go by in the initial phases of therapy, the therapist does not yet know what style the client will be most receptive to, and the therapist is already in the anxiety-provoking situation

of establishing a new relationship. Thus, decisions regarding how to respond to a client's question can be further complicated by the phase of the therapeutic process in which they occur. Adding to this complexity, client characteristics, including age, sex, presentation of question, behavior, past experience, presenting complaint, degree of distress (Chakraborti, 2006), therapists' comfort level, underlying client-concerns, and clients' best interests (Edelstein & Waehler, 2011) are all variables that may also influence a therapist's response to clients' questions.

At the same time as client questions' potentially challenge therapists' efficacy, such moments may also indicate an opportunity for therapeutic growth. For example, Feldman (2002) asserted that client questions can enhance the therapeutic process by providing the therapist with valuable information about the client's internal world, providing the therapist with the opportunity to socialize the client to the therapeutic process, and, when responded to with care by the therapist, client questions can enhance client-therapist rapport, and promote the client's own curiosity about his/her internal world. Wachtel (2011) mirrored Feldman's (2002) assertion, indicating that clients' questions can help therapists understand their clients on a deeper level by providing the therapist with valuable information that will aide in gaining a more comprehensive understanding of clients' worlds. Additionally, Brodley (1995) wrote, "At our best, the interactions about clients' questions and requests come from as deep a source in ourselves as pure empathetic interactions" (p. 2), indicating that responding to client questions carefully can greatly enhance communication between client and therapist. Thus, although clients' questions can be off-putting for therapists, such questions may also have the potential to enhance the therapeutic process in significant ways.

Given the complex nature of responding to client questions, the anxiety such questions can cause therapists, and the potential for client questions to enhance the therapeutic process, Edelstein and Waehler (2011) developed a set of guidelines to help therapists respond to client questions in ways that promote therapeutic growth. These guidelines are intended to outline effective responses to client questions regardless of therapists' skill levels, phases of therapy, and client contexts. As yet, these guidelines have not undergone empirical scrutiny. Thus, the purpose of the current study is to 1) identify theoretical support for these guidelines, and 2) ascertain whether these guidelines contribute positively to the therapeutic endeavor by testing whether their use results in the three desirable therapeutic outcomes identified by Edelstein and Waehler (2011).

This paper will begin by describing some of the major therapeutic orientations' viewpoints regarding responding to client questions, followed by a review of the available literature regarding suggestions for responding to client questions. Edelstein and Waehler's (2011) four guidelines for answering client questions are then introduced along with their three desirable therapeutic outcomes that the guidelines are intended to produce. A thorough examination of the theoretical support for each guideline and how each guideline may result in the desirable outcomes follows. Specific hypotheses are then outlined and lead into the methodology undertaken in the current study. Finally, this paper reviews the results of this empirical examination of whether Edelstein and Waehler's guidelines are perceived to produce the desired therapeutic outcomes.

### **What Theory Suggests**

Various theoretical orientations present conflicting ideas regarding how to respond best to client questions. Traditional psychoanalytic literature stresses the importance of therapists'

restraint from gratifying client wishes (Freud, 1915). The psychoanalytic perspective holds that by gratifying clients' wishes inherent in their questions (i.e. responding to their transference hopes, expectancies, and fears), therapists will decrease clients' level of internal conflict, thereby hindering the resolution process, which is viewed as the impetus of change (Dewald, 1992). From this perspective, providing direct answers to client questions precludes clients' experiences of conflict and subsequent insight into particular meanings underlying the questions (Glickauf-Hughes & Chance, 1995).

Although for very different reasons, humanistic ideology also discourages direct answers to client questions. From the humanistic perspective, part of the impetus of client change (viewed as personal growth) lies in the therapist empowering the client to realize that he or she is responsible for him/herself. As Rogers, the founder of client-centered therapy, stated, if therapy is effective, a client will be able to "choose, on his own initiative and on his own responsibility, new goals that are more satisfying than his maladaptive goals" (1946, p.p. 416-417). Answering clients' questions may undermine the therapeutic process by precluding clients' acquisition of responsibility for their presenting concerns and their resolutions.

Once the strict orthodox of these positions is modified, there is greater ambivalence regarding the most effective ways to respond when clients ask questions. For example, Langs (1973), a psychodynamic theorist, held that frustrating a client unnecessarily by refusing to answer any questions can inhibit the therapeutic process. Likewise, another psychodynamic theorist, Wachtel (1993), held that refusing to answer certain client questions can lead to an implicit power struggle between client and therapist, which can have a deleterious effect on the clients' fantasies about the therapist as well as the working alliance. Similarly, humanistic therapists face a dilemma in considering responses to client questions. Basescu (1990) suggested

that responding genuinely to client questions can convey therapists' respect for clients and can enhance the client-therapist relationship—an essential part of humanistic therapy. Thus, the humanistic therapist faces an impasse: how can a therapist display respect for the client, thereby maintaining the strength of the client-therapist relationship, while simultaneously refraining from answering client questions in order to promote clients' autonomy? Kemp (2004) spoke directly of this dilemma when she wrote:

To be literally non-directive, the therapist might systematically refrain from responding to a client's questions, but this would be inconsistent with the true meaning of the nondirective attitude, misinterpreting it as a technique. Systematic, literal, non-directivity in response to questions can be perceived by the client as an act of authority about what is good for the client or be experienced as disrespect. If the client feels that he or she is not accepted or respected, the necessary therapeutic attitudes will not have been provided (p. 5).

Extending the ambivalence noted in humanistic theory regarding whether or not to respond to client questions, Brodley (1997) noted that, at times, a simple empathetic response to a client's question can be therapeutic in and of itself; however, she stated that if the client's requests for concrete answers are consistently denied, then the client's sense of self and/or personal power in the situation may be diminished.

These psychoanalytic and humanistic theorists offer the most direct suggestions regarding how to effectively respond to client questions; other theoretical orientations seem to guide therapists' responses to client questions indirectly, if at all. Behavior therapies, derived from B.F. Skinner's theory of operant conditioning (1953), are based on the notion that only behavior (as opposed to thoughts and feelings) can be measured empirically, and should therefore be the sole



focus of therapy. Thus, behavioral theory provides scant guidance for responding to client questions, as such questions and responses would be considered irrelevant to the therapeutic process (Edelstein & Waehler, 2011).

Cognitive therapies (based in part on the work of Aaron Beck [1976] and Albert Ellis [1975]) suggest that individuals' emotions and perceptions are affected primarily by their own internal dialogues. In this way, cognitive-behavioral therapies (CBTs) rest on the assumption that psychological disorders stem from dysfunctional thinking, and include aspects of behavioral therapies (i.e. reinforcement/shaping procedures) in the therapeutic process as well (Dowd & Kelly, 1980). As cognitive therapy and CBTs focus on conscious thought, the implications of the client-therapist relationship and client insight are de-emphasized; thus, techniques regarding how to respond to client questions would likely only be relevant if the responses promote the cognitive strategies employed by the therapist (Edelstein & Waehler, 2011). Within this framework, client questions are likely seen as appropriate to educate the client about overcoming dysfunctional cognitive processes and restoring more constructive thinking consistent with the therapeutic undertaking. Client questions, which are not related to core therapeutic strategies may be ignored, dismissed, or re-directed.

Feminist therapy, with its emphasis on the egalitarian relationship between the client and therapist as well as its goal of increasing clients' abilities to gain and utilize power (Brown, 2010), offer some insight as far as whether and how to answer client questions. Edelstein and Waehler (2011) point out that from the feminist perspective, it may be necessary to answer client questions directly, as the goal of the egalitarian relationship between client and therapist is promoted, in part, to model personal responsibility and assertiveness (Brown, 2010). In addition, Edelstein and Waehler (2011) posit that answering client questions aids the process of

helping clients to gain and use power effectively (a tenet of feminist therapy) by demonstrating that they are able to elicit responses. Thus, it appears that feminist theory, although not directly addressed in the literature, supports therapists providing direct answers to client questions. However, Edelstein and Waehler (2011) also point out that as the basic tenets of feminist theory (i.e. the egalitarian client-therapist relationship; the teaching of power) can blend with other theoretical orientations, potential theoretical conflicts with regard to responding to client questions may arise. For example, psychodynamic therapists who subscribe to some of the basic tenets of feminist therapy may feel torn between refraining from providing answers to client questions, thereby enhancing client insight, and directly answering client questions, thereby strengthening the client's power as well as the egalitarian nature of the client-therapist relationship.

### **Early Suggestions for Answering Client Questions**

Working from a psychodynamic perspective, Glickauf-Hughes and Chance (1995; Glickauf-Hughes, 1998) presented early suggestions for answering client questions. These researchers suggested first differentiating between types of client questions, and then answering (or refraining from answering) the questions based on the category of question. The authors differentiated between 1) genuine requests for information, 2) indirect requests for information, 3) questions that are really statements, 4) questions that are tests, and 5) questions that push the therapist's boundaries.

According to Glickauf-Hughes and Chance (1995), *genuine requests for information* (questions with overt motives, usually posed in the beginning of therapy, i.e. questions about therapists' qualifications, fees, hours, etc.) should be answered out-right. When faced with *indirect requests for information* (questions that covertly express clients' wishes for gratification

from therapists), therapists should respond in such a way as to clarify the true meaning of the question, help clients process the meanings behind the question, and help clients discover their reasons for their resistance to expressing underlying wishes outright. If a genuine question lies beneath the indirect request for information, then the therapist should answer the question after uncovering the client's motivation for asking the question in an indirect manner. Regarding the third category of client questions, *questions that are really statements*, Glickauf-Hughes and Chance stated that such questions are "usually hostile or critical," (p. 378) and that therapists should respond to the question by interpreting (or asking the client to interpret) the meaning or feeling behind the question, responding with empathy for the underlying feeling, and then helping the client to process the reasons for refraining from expressing his/her feelings outright. *Questions that are tests* (or challenges to the therapist) are the fourth category of questions outlined by Glickauf-Hughes and Chance. The authors suggested that such questions could be responded to by 1) answering the question and then helping the client to process the underlying meaning, 2) giving several different hypothetical answers in order to uncover the client's covert wish, or 3) stating a specific interpretation of the covert challenge hidden in the question, and letting the client then respond to the interpretations. Regarding *questions that push the therapist's boundaries*, Glickauf-Hughes and Chance hypothesized that there is a projective identification component to such questions (see: Grotstein, 1981) and/or that they could reflect the clients' desire to ascertain whether or not therapists can set appropriate boundaries. Such questions should be confronted directly by the therapist pointing out these possible underlying meanings (Glickauf-Hughes & Chance, 1995).

Although Glickauf-Hughes and Chance's (1995) suggestions are important in that they add to the limited literature in the mental health profession regarding how best to answer client

questions, there are some potential limitations in their application. First, these guidelines are rooted in the psychodynamic tradition, using such concepts as gratification, projection, and transference (to name a few). Therapists subscribing to orientations other than psychodynamic may not find these suggestions useful nor consistent with their overall work with clients. Second, differentiating between the various types of client questions may be too complicated to be used in a typical therapy session, particularly for novice therapists (who also feel the most apprehension in responding to client questions; Edelstein & Waehler, 2011). In addition, although the authors describe client outcomes that may be expected after answering clients in these various ways, the outcomes are also embedded in a psychodynamic framework that may not fit with many therapists' orientations (i.e. "...the therapists enable the client to: [1] reintegrate the projected aspect of themselves, or [2] understand some aspect of their childhood that they are acting out rather than remembering;" Glickauf-Hughes & Chance, 1995, p. 379). Finally, the authors' statements regarding outcomes are vague and could be difficult to measure empirically (i.e. "Addressing the client's resistance to expressing his/her needs directly strengthens the client's observing ego capacities and working alliance with the therapist, enabling the client to explore more fully his/her fears and fantasies related to the specific incident," p. 378).

Feldman (2002) also addressed the complexities of responding to client questions from a psychodynamic perspective. Like Glickauf-Hughes and Chance (1995), Feldman categorized client questions by the underlying reasons that the questions were asked; however, Feldman focused on questions posed at the beginning stages of therapy. She stated that clients typically ask questions for one of five reasons: "1) to obtain information, 2) to express anxiety or test the therapeutic waters, 3) to deflect attention away from oneself, 4) to resolve conflicts, and 5) to seek engagement" (2002, p. 215). In addition, Feldman described four typologies of client

questions: “1) questions about the clinician’s availability; 2) questions about the clinician’s competence; 3) questions about the clinician as a person and her life experiences, and 4) questions about the nature and extent of treatment” (2002, p. 220). Regardless of the type of question, Feldman stated that it is best to relate the client’s questions to his/her presenting concern, if at all possible, as doing so demonstrates to the client that the therapist is listening, illustrates to the client *how* the therapist is listening, orients the client to the therapeutic process, and demonstrates to the client the interrelated nature of his/her thoughts and feelings. Feldman next provided five general statements that therapists can use to respond to client questions: 1) “Can you help me understand why that information is important for you to know?” 2) “Can you help me understand how that information will help you?” 3) “I have found that people ask questions that are really important to them. Perhaps you could help me understand why that question is important to you.” 4) “I have found that the questions people ask are related to some of their difficulties. It might be helpful if you could tell me a bit more about your question.” And 5) “I am concerned that if I simply answer your questions I would be robbing us of the opportunity to understand what might lie behind the question.” (2002, pp.224-225).

Feldman’s (2002) suggestions provide important insight regarding the significance of client questions and the importance of therapists answering them in ways that enhance the therapeutic process. However, there are a number of issues regarding responding to client questions that Feldman did not address. First, Feldman focused on client questions that are posed in the initial stages of therapy. Although such questions certainly present unique challenges that warrant consideration, they do not encompass a wide array of important client questions that are generally asked further into the therapeutic process (e.g., “Do you think I’m better yet?” “How much more therapy do you think I need?”). Second, by describing clients’ questions in-depth and

categorizing the questions by five underlying meanings and four typologies, Feldman's (2002) article is heavily focused on describing the importance of understanding client questions; the actual technique of responding to clients' questions seems to receive only secondary attention. In addition, although Feldman's description of client questions, and the technique for responding to them, could be used across therapists' theoretical orientations, Feldman explicitly stated that her paper "is offered as a contribution to the growing literature on psychodynamic technique" (2002, p. 214). Thus, Feldman's conceptualization of client questions and justification for responding to them in certain ways is embedded in one theory. As with Glickauf-Hughes and Chance's (1995) guidelines, therapists subscribing to orientations other than psychodynamic may not find Feldman's considerations for responding to client's questions applicable. Finally, although Feldman briefly stated that therapists' ability to handle client questions "skillfully and tactfully" lead to certain desirable outcomes (e.g., helping the therapist better understand the client; giving the therapist the opportunity to socialize the client to therapy; enhancement of client-therapist rapport; and cultivation of curiosity), she does not describe how these outcomes may result directly from responding to client questions using her five general responses (2002).

Approaching responses to client questions from a non-directive, client-centered framework, Brodley (1987) described four steps that she takes when responding to client questions. These steps are: 1) Empathizing with the client in order to clarify the meaning of the question, 2) explaining the methodology and information sources that were utilized when answering the question, 3) checking with the client to ensure that the question was adequately addressed and to discuss any of the client's reactions to the answer, and 4) treating the client's responses to the therapist's answer as any other client communication—with empathetic understanding. Brodley's (1987) steps to answering clients' questions illustrate the client-

centered nature of humanistic theory; however, the steps do not address the dilemma that humanistic therapists often face (as discussed in the previous section) regarding the decision to answer a client's question in the first place. If the therapist believes that answering a client's question is detrimental to the client's growth process, then the therapist has little guidance based on Brodley's four steps. Furthermore, therapists subscribing to frameworks in which the therapist is viewed as an expert or authority (e.g., behavioral therapists, cognitive therapists) may not find such nondirective steps useful. In a later writing, Brodley (1995) developed a list of questions that a therapist should ask him/herself before responding to a client's question (e.g., "Do I feel at ease with the question or request? Am I comfortable enough with it to address the question or request without being distracted or defensive?" and "Do I need to postpone a response to think about it further, or to regain my congruence?") (pp.1-2). Although these self-directed questions may provide the therapist with valuable insight regarding the nature of responses to clients' questions, these questions provide little guidance regarding what actual response could be offered to clients' questions. Also, such self-directed questions may foster the empathy and genuineness characterized by non-directive client-centered therapy, but again, therapists subscribing to other orientations may not find such questions particularly helpful.

In a retrospective study of transcripts of therapy sessions and interviews conducted by Carl Rogers from 1940-1986, Kemp (2004) qualitatively analyzed Rogers' non-directive style of responding to client questions. Kemp concluded that the founder of non-directive, client-centered therapy (Carl Rogers) did not use any specific techniques for answering clients' questions, but rather embodied the values of therapist genuineness, unconditional positive regard, and empathy that are characteristic of non-directive therapy. Rogers used several different types of responses (e.g., brief direct verbal or non verbal answers to clients' questions, extended direct verbal or

nonverbal answers, indirect answers, empathetic understanding responses that pertained to the client's question, empathetic understanding responses that did not pertain to the client's question). From Kemp's perspective, the specific content of Rogers' responses mattered less than his overall non-directive attitude that his responses embodied; the client-centered therapist need not be overly concerned with *what* is said in a response to a client's question, so long as the response is characterized by empathy, genuineness and unconditional positive regard (2004).

The experienced client-centered therapist may find Kemp's analysis of Rogers' responses to client questions valuable in developing responses to client questions that are congruent with client-centered ideals. However, as with Brodley's (1987, 1995) suggestions for responding to client questions, therapists subscribing to more directive frameworks may not find Kemp's analysis helpful. Furthermore, novice therapists (even novice therapists who are trained in client-centered, non-directive values) may derive little benefit from the analysis of Rogers' responses; novice therapists may have yet to develop an adequate identity as a client-centered therapist that would allow them to respond to clients' questions with the spontaneity and adherence to non-directive values characterized by Rogers' responses.

Brodsky (2011) took an entirely different approach to client questions, suggesting that client questions should not be permitted in the first place. Brodsky posited that therapeutic growth may, in part, result from clients learning how to "make straightforward and candid requests of others in their lives" (2011, p. 95), suggesting that question-asking in any context can hinder relationships by preventing individuals from expressing true wants and desires. Brodsky stated, "I have rarely heard a client say, 'What I want from you is...' That form of simple request is a good substitute for client questions" (Brodsky, 2001, p. 95). Thus, Brodsky suggested that therapists instruct clients to simply state their thoughts, feelings, and needs, rather than



encouraging them to ask questions. More specifically, Brodsky stated that there are three types of questions that clients should not ask: 1) causal questions, 2) questions regarding resolutions, and 3) self-serving questions by coerced clients (2011). *Causal client questions* involve the client asking “why?” he or she is experiencing the malady that brought him/her into therapy. Brodsky posited that such questions do not move the therapeutic process forward, as the answer in the beginning of therapy will likely be unknown, and the answer further into therapy will likely depend on the therapist’s orientation (e.g., a cognitive therapist may attribute negative self-evaluations; a psychodynamic therapist may attribute past traumas), making the answers somewhat arbitrary. Furthermore, Brodsky contended that however the therapist answers the “why” question, the underlying goal of the question (which Brodsky stated is for the client to find out her/his prognosis) goes unaddressed. *Questions regarding resolution* refer to client questions that look to ascertain how long the client will need to be in treatment in order to feel better (Brodsky, 2011). Brodsky stated that most therapist answers will be some variation of “it depends” or simply “I do not know,” either of which does not help the client move forward in the therapeutic process. *Self-serving questions by coerced clients* refers to questions posed by coerced clients, usually characterized by the underlying question of “What do I have to do to get out of here?” (Brodsky, 2011). Brodsky stated that issues related to this question (such as attendance, progress, limits of confidentiality, etc.) should be addressed thoroughly early in therapy, precluding the need for the client to ask such questions later on.

Brodsky’s (2011) rather unconventional stance on client questions neglects several important points. First, although a therapist could outwardly discourage questions early in the therapeutic process, Brodsky does not address what a therapist should do if a client asks a question anyway. It is unclear, from Brodsky’s perspective, whether the therapist should simply

not respond to the question or whether he believes a response is acceptable, just not particularly therapeutic. Second, Brodsky's stance on client questions is embedded in a broader belief that therapists should not ask clients questions either, as such questions impede the therapeutic process (see: Brodsky, 2011). Thus, it may be that client questions, in the absence of therapists' questions, throw the basic trust of the client-therapist relationship into discord. Furthermore, Brodsky's discussion of client questions seems incomplete. Although he stated that in general, clients should use straightforward statements instead of questions, Brodsky only touches on three different types of questions (causal questions, questions regarding resolution, and self-serving questions by coerced clients) that clients should not ask, which only likely account for a small portion of all of the questions a client could potentially ask. In addition, Brodsky's discussion of client questions (2011) is a chapter in a larger work that discusses the implications of providing therapy for reluctant or coerced clients. Although Brodsky's general stance on question asking is that both clients and therapists should not ask questions, Brodsky never explicitly stated whether his stance on question asking is different for willing clients. Finally, in order to subscribe to Brodsky's viewpoint, a therapist must disregard the potential benefits of clients asking questions posited by several other theorists (Edelstein & Waehler, 2011; Feldman, 2002; Glickauf-Hughes & Chance, 1995; Wachtel, 2011).

Although Brodsky's (2011) work does not suggest guidelines for answering client questions, it does add to the scant body of literature regarding the implications of client questions. Glickauf-Hughes and Chance (1995) and Feldman's (2002) conceptualizations of client questions, as well as their considerations for responding to questions, represent important strides toward a better understanding of how therapists can respond to their clients' questions in ways that enhance the therapeutic process; however, they also illuminate the need for a straight-

forward, comprehensive guide to help therapists respond optimally. In short, what is needed is a framework for answering client questions that could be used across therapeutic orientations, stages of therapy, and skill-levels, and that are tied to specific and measurable outcomes.

### **Edelstein and Waehler's Guidelines for Answering Client Questions**

In their book, Edelstein and Waehler (2011) provided four guidelines for answering client questions that they contend can be applied across orientations and skill levels. These authors take a general approach that client questions within psychotherapy can best be used as exploratory opportunities in addition to being explanatory moments (Waehler, personal communication, October 19, 2012). The guidelines are: 1) therapists should receive the client's question respectfully; 2) therapists should promote the client's curiosity about the question; 3) therapists should answer the client sufficiently in order to keep the client engaged; and 4) therapists should explore possible underlying and idiosyncratic meanings with the clients (Edelstein & Waehler, 2011, p. 13-14). The authors proposed that utilizing these guidelines sufficiently should result in three desirable outcomes that can enhance the therapeutic process: 1) the client will explore an expanded breadth of material; 2) the client will explore an expanded depth of material; and 3) the connectedness between the client and the therapist will be enhanced.

Psychotherapy outcome research supports these three desired outcomes as enhancing the therapeutic process. Regarding the first two specified outcomes (clients will explore an expanded breadth of material covered; clients will explore an expanded depth of material covered), one's ability to think more broadly and deeply about his/her world (e.g., thoughts, feelings, observations) by discovering the reasoning behind his/her thoughts, feelings, and behaviors has been shown to lead to a greater sense of control and self-efficacy (Frank & Frank,

1991; Hanna & Richie, 1995). Similarly, client-therapist connectedness (desired outcome 3) is a reliable predictor of positive therapeutic outcomes (Brown & Lent, 2008). “Connectedness” between therapist and client, or therapeutic alliance, is more widely researched than any other component of the therapeutic process, and is a consistent predictor of psychotherapeutic success (Gelso & Samstag, 2008; Horvath & Bedi, 2002). Indeed, regardless of a therapist’s theoretical orientation, ability to maintain a strong therapeutic alliance has been shown to be a key factor in client change (Orlinsky, Grawe, & Parks, 1994).

The three desirable outcomes outlined by Edelstein and Waehler (2011) seem to be inherently connected to one another; several psychotherapy theories recognize the need for a strong therapeutic relationship in order to facilitate client growth (enhanced breadth and depth of thought). For example, classic theorists such as Sigmund Freud and Carl Rogers seemed to believe that the therapeutic relationship was the vessel by which clients’ broadening and deepening of thought and feeling could be achieved. Freud (1912) asserted that a strong therapeutic relationship can help clients to deepen their understandings of their internal worlds. Similarly, Rogers asserted that the distinctive features of the client-therapist relationship that create an environment where the client feels safe from judgment are vital in order for a client to feel safe in expressing “deep and motivating attitudes,” as well as to explore “attitudes and reactions more fully than he has previously done” (1946, p. 416).

Contemporary research supports these early theorists’ ideas. For example, Lietaer (1992) conducted a content analysis of clients (N=41) and their therapists’ comments during 325 psychotherapy sessions. Lietaer’s findings showed that both the clients and the therapists viewed self-exploration and experiential insight as the most important factors in the therapeutic process. Furthermore, Lietaer found that clients believed that they were more likely to achieve enhanced

self-exploration and experiential insight when there was a high level of connectedness. Similarly, Binder, Holgersen and Nielsen (2009) conducted a qualitative analysis of former psychotherapy clients' beliefs about their change processes throughout psychotherapy. These authors clustered the former clients' responses around four change process/event themes: 1) having a relationship with a therapist who was "wise, warm, and competent," 2) having a stable relationship with the therapist during times of inner turmoil, 3) correcting false assumptions and beliefs about the clients' selves and their worlds, and 4) creating new meaning in the clients' life patterns. The first two change processes that the former clients articulated in Binder et al.'s study mirror Edelstein and Waehler's (2011) desired outcome of "increasing client-therapist connectedness," while the last two change processes that the former clients articulated reflect Edelstein and Waehler's first two desired outcomes: enhancing breadth of material covered by clients and enhancing depth of material covered by clients.

### **Importance of Edelstein and Waehler's Guidelines**

Taken together, Edelstein and Waehler's (2011) guidelines for responding to client questions may indeed lead to the outcomes of clients' increased breadth of material covered, increased depth of material covered, and increased connectedness between the client and the therapist, which would enhance the therapeutic process. Although questions posed by clients can create apprehension for the therapist (Chakraborti, 2006; Edelstein & Waehler, 2011; Feldman, 2002; Glickauf-Hughes & Chance, 1995), and mishandling questions may serve as an impediment to effective therapy, responding appropriately to client questions can enhance the therapeutic process perhaps even more effectively than in other therapeutic interactions (Wachtel, 2011).

Edelstein and Waehler (2011) are not the first to suggest that clients' questions can contribute positively to therapy; Feldman (2002), speaking from a psychodynamic perspective, proposed that client questions could enhance the therapeutic process because effective responses reveal information about clients' internal worlds (i.e. concerns and aspirations), give the therapist the opportunity to orient the client to the therapeutic process, strengthen the therapeutic process, and cultivate clients' introspection as far as their internal motivations for asking the question. Where Edelstein and Waehler's guidelines (2011) for answering client questions extend Feldman's work is by proposing specific guidelines that are said to be useful across therapeutic orientations, skill levels, and that could promote specific desirable therapeutic outcomes.

Edelstein and Waehler (2011) have noted, from their own and others' experiences, that responding to client questions in ways that align with the four guidelines seems to result in the three desired outcomes. However, the guidelines that Edelstein and Waehler created were primarily developed from the authors' and their colleagues' clinical and supervisory experiences (Edelstein & Waehler, 2011). What is needed is a study that will examine empirically the effectiveness of Edelstein and Waehler's guidelines in producing the desired therapeutic outcomes. What follows is an extended articulation and justification for the guidelines, which will help establish the parameters of the current study.

### **Receiving the question respectfully**

Therapist respect is widely recognized as an essential component of client-therapist connectedness (desired outcome 3) (Bemporad, 1995; Patterson & Holden, 1985, Rogers, 1957; Truax & Carkhuff, 1967), which, in turn, has been considered the most consistent predictor of therapeutic outcomes (Gelso & Samstag, 2008; Hovarth & Bedi, 2002). For example, Patterson (1989) included therapist respect for clients as one of the three common therapist elements that

“define a therapeutic relationship that provides the specific treatment variables for psychological emotional disturbances” (p. 433). Rizzuto (1993) (using the dictionary definition of respect—“noticing with attention”), posited that therapist respect communicates that a client is deserving of therapeutic attention and that the therapist is committed to understanding and reflecting back the clients’ psychological state. Furthermore, Bemporad (1995) suggested that therapist respect (along with humanity and genuine concern) for clients is an active ingredient in the treatment of depression, as clients who suffer from depression are often used to being abused, rejected and mistreated; Bemporad posited that by showing depressed clients respect (as well as humanity and concern) within the therapeutic relationship, clients can begin to see themselves in a more positive light. Thus, the bulk of the empirical and theoretical support for the guideline, *receiving the client’s question respectfully*, relates to desired outcome 3, *increased client-therapist connectedness*. Indeed, in one of the few writings directly addressing ways to effectively respond to client questions, Brodley (1987), speaking from a client-centered framework, stated that “...treating questions respectfully (and thereby treating the client respectfully) contributes to the quality of the relationship experienced by the client” (p. 13).

In a similar vein, researchers have identified several factors directly related to therapists’ respectfulness that contribute to client-therapist connectedness (desired outcome 3). For example, Price and Jones (1998) showed that conveying understanding and support (characteristics demonstrated when a therapist shows respect for a client’s questions) significantly and positively impacted the client-therapist relationship. Likewise, Najavits and Strupp (1994) demonstrated that clients who viewed therapists as affirming (a therapist characteristic conveyed through being respectful) and understanding also reported stronger working alliances. Therapists’ ability to respond nondefensively to criticism and confrontation

(which can serve as underlying motives of certain client questions [Feldman, 2002; Glickauf-Hughes & Chance, 1995]) from clients has also been shown to enhance clients' feelings of trust and being understood by their therapists (connectedness) (Bachelor, 1995). Finally, as Rizzuto (1993) suggested, by conveying respect for a client the therapist demonstrates effortful awareness of the client's thoughts, words, and behaviors. Such therapist exploration into clients' worlds has been shown to enhance client-therapist connectedness as well (Bachelor, 1991; Gaston & Ring, 1992).

In addition to resulting in desired outcome 3 (increased client-therapist connectedness), receiving questions respectfully could help clients increase their exploration of breadth and depth of material covered during therapy (desired outcomes 1 and 2). In this vein, Edelstein and Waehler (2011) suggest that respect can be conveyed, in part, through reflection and paraphrasing in an attempt to fully understand what the client is asking. These actions by the therapist are thought to lead the client toward exploring his/her thoughts in a more comprehensive fashion (Edelstein & Waehler, 2011). Feldman (2002) also implied that receiving client questions respectfully can lead to enhanced client breadth and depth of material explored. Feldman noted that clients' questions often stem from specific concerns that clients are too insecure to express directly. Thus, if a therapist can work to respectfully receive a client's question and to genuinely understand what the client is asking, the client may feel accepted by the therapist, and thus, less insecure. This could make the client more comfortable in expressing his/her thoughts and feelings more broadly and deeply. Finally, in their case study of therapeutic immediacy in psychodynamic psychotherapy, Mayotte-Bul, Slavin-Mulford, Lehmann, Pesale, Becker-Maturo, and Hilsenroth (2011) noted that the therapist's support and validation (elements



of respect) of the clients feelings and concerns led to the client's broader and deeper exploration of her fears and concerns in the therapeutic relationship (desired outcomes 1 and 2).

### **Promoting client curiosity about the question**

Curiosity plays a fundamental role in human motivation and well-being (Kashdan & Stegar, 2007; Peterson, Ruch, Beerman, Park, & Seligman, 2007; Peterson & Seligman, 2004); and enhancing curiosity has been cited as one of the primary goals of psychotherapy (Feldman, 2002; Kashdan & Fincham, 2004). Silvia (2006) suggested that when individuals are curious, they display enhanced attention to activities, deeper processing of information, better retention of information, and increased persistence in obtaining goals. These qualities are vital in furthering therapeutic progress. Furthermore, in their study on the role of curiosity in enhanced well-being and life meaning, Kashdan and Stegar (2007) found that higher levels of trait curiosity were associated with more growth-oriented behaviors, enhanced presence of and search for meaning, and greater life satisfaction. Indeed, as Tomkins (1962) stated, "The importance of curiosity to thought and memory are so extensive that the absence...would jeopardize intellectual development no less than the destruction of brain tissue...there is no human competence which can be achieved in the absence of a sustaining interest" (p. 347). In these ways, promoting clients' curiosity through therapeutic interaction may contribute to enhanced overall well-being and clients' questions provide an ideal opportunity to enhance such curiosity through validation and positive reinforcement (Edelstein & Waehler, 2011).

Clients' questions often have covert intentions (Feldman, 2002; Glickauf-Hughes & Chance, 1995; Greenson, 1967; Wachtel, 1993); delving into the meaning behind such questions can encourage client curiosity. As Wachtel (1993) suggested, different questions have different meanings for different clients; understanding the meanings behind the questions and inviting

clients to understand those meanings could be a useful tool in responding to client questions (This notion also applies to guideline 4, exploring underlying and idiosyncratic meaning of questions with clients, as will be discussed in the corresponding section of this paper). For example, Glickauf-Hughes and Chance (1995) stated that client questions such as “Do you ever see clients more than once a week?” could indicate that a client wants to see the therapist more often but is too embarrassed to express this desire outright. On the other hand, this might be a question by which a client is trying to assess his/her level of conflict or normality. Thus, it would be important for the therapist to clarify a possible hidden message and then explore the reasons why the client did not express the message overtly (e.g. the client was unaware of the meaning; the client was afraid of displaying neediness; the client was afraid of rejection). By promoting the client curiosity expressed in the questions, therapists model curiosity about the client’s world, thereby enhancing client’s own self-exploration (Basescu, 1990; Feldman, 2002; Greenson, 1965).

Promoting client curiosity is in line with Edelstein and Waehler’s (2011) first two desired outcomes of enhanced client exploration of breadth and depth of feeling and thinking. If a client becomes more curious about his or her world, then he or she would be motivated to explore a wider range of thoughts and feelings (breadth), as well as develop a more coherent understanding of thoughts and feelings (depth). In addition, this collaboration between therapist and client in valuing client curiosity inherent in his/her exploring meanings behind questions collaboratively, could enhance connectedness (outcome 3). Several studies have noted that use of exploratory strategies in a therapeutic setting enhances connectedness between client and therapist (Bachelor, 1991; Gaston & Ring, 1992; Mohl, Martinez, Tichnor, Huang, & Cordell, 1991).

### **Answer Sufficiently to Keep Client Engaged**

Even theorists who are strongly opposed to answering clients' questions concede that answering some questions can be beneficial. For example, Langs (1973), a psychodynamic theorist who held that, on the whole, client questions should not be answered, cautions that frustrating clients unduly by refusing to answer realistic questions may be counterproductive. Likewise, although Greenson (1967) held that answering client questions inhibits clients' self-exploration, he stated that occasionally answering questions can be appropriate. Similarly, Feldman (2002) suggested that while answering client questions can hinder a client's exploration of his/her internal world, refusing to answer all client questions can leave the client feeling misunderstood or mocked. As clients report feeling more connected when the therapists are viewed as empathetic, congruent, and demonstrating positive regard (Horvath & Greenberg, 1989), a categorical refusal to answer any client question could indeed inhibit the client-therapist relationship (desired outcome 3).

Although the traditional psychoanalytic view of answering client questions suggests that answering clients' questions leads to an inhibition of the client's processing and exploration of deeper meanings (Freud, 1915, Greenson, 1967; which relate to outcomes 1 and 2), it is possible that clients' further processing and exploration could be hindered by categorically withholding answers as well. For example, Wachtel (1993) held that refusing to answer all clients' questions can lead to an implicit power struggle between the client and the therapist, which can hinder the clients' fantasies about the therapist as well as the client's willingness to share those fantasies. Not sharing such wonderings could damage the client-therapist connection and also inhibit clients' full exploration of their thoughts and emotions with the therapist. Humanistic theory also supports the notion that answering clients' questions may enhance clients' processing and exploration. Brodley (1997), for example, pointed out that if a client senses that a therapist

avoids answering any questions, then the client may begin to believe that it is not appropriate to ask questions; this inhibits clients' freedom of expression (which is related to desired outcomes 1 and 2). Thus, a categorical refusal to answer all client questions may preclude attaining *any* of the three desired outcomes; as Basescu's (1990) posited, by genuinely responding to client questions, a therapist conveys respect to the client, thus enhancing collaboration and further therapeutic progress.

Bugental (1987), a humanistic theorist, contended that the most important factor in therapists' answers to client questions is the therapists' honesty; this speaks to the idea of answering clients' questions "sufficiently." Bugental suggested that when appropriate, simply and honestly acknowledging to the client that providing an explicit answer to his/her question can hinder self-exploration could be part of the therapist's response (1987). Thus, it is important to note that what constitutes a "sufficient" answer to a client's question varies by the client and the context of the client's question (this will be discussed in greater detail in the following section, "*Explore Underlying and Idiosyncratic Meanings*"). There are times that a "sufficient" answer may mean providing minimal information to a client so as not to overwhelm the client's sensibilities. Minimal answers to clients' questions, such as Bugental's (1987) suggestion of expressing to the client the benefits of not directly answering his/her question, may even be optimal; such a response could help therapists maintain connectedness with clients (desired outcome 1) while simultaneously promoting clients' breadth and depth of thought (desired outcomes 1 and 2).

By using guideline 3 (answering questions sufficiently) in conjunction with guideline 2 (promoting client curiosity), a therapist could both help clients explore and process the meanings of the clients' questions, while simultaneously preserving the quality of the therapeutic

relationship. As Wachtel stated, “One should not equate answering the question with abandoning one’s interest in understanding its meaning and, conversely and equally important, one should not assume that the only way to discover its meaning is to refuse to answer it” (1993, p. 225). Indeed, the guidelines outlined by Edelstein and Waehler suggested that a therapist need not choose between answering client questions to maintain connectedness and refusing to answer client questions to promote clients’ self-exploration. Practiced judiciously, therapists can provide both an explanation within their response as well as promoting exploration.

### **Explore Possible Underlying and Idiosyncratic Meanings with Client**

Several theorists express the importance of recognizing that client questions can have different meanings depending on client and contextual variables (i.e. Feldman, 2002; Glickauf-Hughes & Chance, 1995; Wachtel, 1993). Feldman (2002) suggested the need for therapists to respond to clients’ questions with more questions in order to gain an understanding for the motivation behind the client’s question. Feldman stated that client questions could reflect the client’s desire to build rapport with the therapist (i.e. the client asks how the therapists’ weekend was in order to build a connection with the therapist), the client’s desire to deflect attention away from himself/herself (i.e. the client asks how the therapist’s weekend was in order to avoid discussing his/her own weekend), or the client’s desire to get a handle on the therapist’s availability for him/her (i.e. the client asks how the therapist’s weekend was in order to gauge how busy, and thus, how available the therapist is to the client). By expressing curiosity about the motivation behind a client’s question, Feldman suggested that therapists express interest in the client, which strengthens client-therapist collaboration and connection (outcome 3), while also modeling inquisitiveness about the client’s experience, which can help the client learn to think more broadly and deeply about his/her internal world as well (desired outcomes 1 and 2).

Greenson (1967), a psychoanalytic therapist who wrote about the importance of not always answering clients' questions, suggested that exploring the specific underlying meanings of clients' questions early in therapy can be useful for both the therapist and the client because such exploration can help both parties gain a greater understanding of what will be helpful in the therapeutic process. Indeed, Glickauf-Hughes and Chance (1995) stated that "understanding why the question is asked is most important, regardless of whether it is answered" (p.376).

Understanding underlying and idiosyncratic meanings of clients' questions underscores the importance of considering clients' individual differences and cultural contexts. As Edelstein and Waehler (2011) suggest, one of the fundamental questions that clients often pose either directly or (more often) indirectly is "are you enough like me that I can be safe here [in therapy]" (Edelstein & Waehler, 2011, p. 263). Many theorists have suggested the importance of engaging clients in open discussions about cultural differences in order for therapists to provide culturally sensitive therapy (e.g., Cardemil & Battle, 2003; La Roche & Maxie, 2003). By exploring underlying and idiosyncratic meanings of clients' questions, therapists can open such discussions about cultural and individual differences, which, in turn, can enhance the therapeutic process by enhancing client-therapist connectedness (as clients experience the therapist as interested in and accepting of individual and cultural differences), and clients' breadth and depth of material explored (as clients feel safer exploring material knowing that the therapist respects their individual and cultural differences and works to understand such differences). As Edelstein and Waehler state, "If a client experiences you as genuinely intent on understanding his experience in the present and in being helpful, despite the obstacles that differences can impose, you are positioned to move forward in therapy" (p. 264). Working to understand underlying and

idiosyncratic meanings of clients' questions thus may lead to increased cultural sensitivity on the part of the therapist, as well as an increase in all three desired outcomes.

### **The Current Study**

Edelstein and Waehler's (2011) four guidelines for responding to client questions and their desired outcomes were developed primarily based on the authors' clinical and supervisory expertise. As this paper demonstrates, Edelstein and Waehler's four guidelines (2011) have strong theoretical support for enhancing the therapeutic process as well (specifically by resulting in the outcomes of increased breadth of material covered, increased depth of material covered, and increased client-therapist connectedness). The current study looks to extend this theoretical support by obtaining empirical data using an analogue study design. Specifically, this study will test two hypotheses: 1) therapy sessions in which a therapist utilizes Edelstein and Waehler's guidelines will produce higher observer ratings of expected client breadth of material explored, client depth of material explored, client-therapist connectedness, and more positive counselor competency ratings than therapy sessions in which the therapist simply reflects the client's question; 2) therapy sessions in which a therapist utilizes Edelstein and Waehler's guidelines will produce higher observer ratings of client breadth of material explored, client depth of material explored, client-therapist connectedness, and more positive counselor ratings than therapy sessions in which a therapist provides a direct, psychoeducational response to the question.

### **Methods**

#### **Participants**

Students (N=140) from psychology classes at The University of Akron participated in the current study. Two people were excluded from the final analysis due to not completing large portions of their materials (i.e. completing only 75% or less of one or more measures). This

resulted in a final sample of 138 students (81 women and 57 men). The ages of participants ranged from 18-39 ( $M = 21.5$ ;  $SD = 4.2$ ). 103 participants identified as Caucasian (74.6%), 22 identified as African American (15.9%), 3 identified as Asian American (2.2%), 3 identified as Arabic (2.2%), 1 participant identified as Hispanic (.7%), 1 participant identified as American Indian (.7%), and the rest of the participants ( $n = 5$ ) identified as biracial or multiracial (3.6%). Participants were primarily psychology majors ( $n = 37$ ; 26.8%), science/math majors ( $n = 30$ ; 21.7%), nursing majors ( $n = 21$ ; 15.2%), or had not decided on a major ( $n = 42$ ; 30.4%), with the remainder of participants in other fields (language arts, business, fine arts, graduate student). Finally, 55 of the participants reported having attended counseling (39.9%), with the remainder of participants ( $n = 83$ ), reporting never having been to counseling. Students received four extra credit points in their psychology classes for their participation. (See Tables 1-4).

A power analysis was computed (using the program G\*Power) to determine this sample size based on requirements for a multivariate analysis of variance (MANOVA) with one between-subjects factor (Faul, Erdfelder, Lang, & Buchner, 2010). The power analysis suggested a total of 108 participants (36 participants in each of the three conditions) were needed to obtain a minimum power of 80% (the minimum suggested power for an ordinary study; Cohen, 1988) for a medium effect size (Borenstein, Rothstein, & Cohen, 2001; Faul, Erdfelder, Lang, & Buchner, 2010). Thus, the current sample of 138 was viewed as sufficient to yield a medium effect size and to minimize the likelihood of making a Type 2 error.

Participants were recruited through the university's Human Participation in Research (HPR) website—a database that provides information to psychology students regarding research projects. The website provides students with criteria for participation for each study, and also tracks the total amount of extra credit points that students earn for their participation in studies.



**Table 1***Descriptive Statistics of Participants by Group: Gender and Race*

	Gender			Race			
	Male	Female	Total	Caucasian	African American	Other	Total
Condition 1	16	31	47	35	6	6	47
Condition 2	21	24	45	35	8	2	45
Condition 3	20	26	46	33	8	5	46
Total	57	81	138	103	22	13	138

**Table 2***Descriptive Statistics of Participants by Group: College Major*

	Psychology	Science/Math	Nursing	Undecided	Other	Total
Condition 1	15	9	7	14	2	47
Condition 2	11	11	10	10	3	45
Condition 3	11	10	4	18	3	46
Total	37	30	21	42	8	138

**Table 3***Descriptive Statistics of Participants by Group: Age*

	18-20	21-23	24-26	27-30	30-39	Total
Condition 1	26	13	5	1	2	47
Condition 2	20	17	5	2	1	45
Condition 3	27	17	2	0	0	46
Total	73	47	12	3	3	138

**Table 4***Descriptive Statistics of Participants by Group: Counseling Experience*

	Yes	No	Total
Condition 1	19	28	47
Condition 2	21	24	45
Condition 3	15	31	46
Total	55	83	138

The HPR website provided students with information regarding the purpose of the study, what would be expected of them, the extra credit incentive, and the primary researcher's contact

information. Participants were given informed consent procedures before their participation in the study began (See Appendix A). Demographic information was then collected (participants' gender, age, race, major, and prior experience in therapy; See Appendix B). Participants were randomly assigned to one of three conditions ( $n = 47$  for condition 1;  $n = 45$  for condition 2;  $n = 46$  for condition 3).

As the current study is the first empirical study measuring perceptions of therapeutic impact based on therapists' responses to client questions, the researchers believe that the use of a convenience sample of college students is appropriate. Such a sample allows for many participants to be recruited and included. Data from the current study may serve to inform the development of future studies that can measure the effectiveness of Edelstein and Waehler's (2011) guidelines for responding to client questions with a broader array of participants (e.g., actual clients). In addition, this study may provide valuable information regarding college students' perceptions of how therapists respond to client questions. Thus, by utilizing college students as participants, this study will inform therapists' work at college counseling centers as well as gather information to help inform future studies.

### **Procedure**

Participants were randomly assigned to one of three conditions. All participants watched the same video of a mock therapy session depicting a first-year college student who is struggling to adjust to college life, a scenario to which these college students could likely relate. This video lasted approximately 10 minutes (See script in Appendix C).

Next, the experimental manipulation took place. Participants in the three different groups were shown a continuation of the initial video in which the client asked the therapist the question, "Do you think I'll get better?" This question was chosen because it 1) is common in

therapy, 2) can be answered with a concrete psychoeducational response, and 3) can be rich with underlying meaning. Edelstein and Waehler (2011) stated that questions such as this (i.e. about change) are often “appeals for assistance and reassurance that [clients] are not incompetent or helpless” (p. 71). The video for group one portrayed the therapist responding to the client’s question utilizing Edelstein and Waehler’s (2011) guidelines for responding to client questions (See script in Appendix D). The video for group two depicted the therapist responding to the client’s question using an alternative response style (psychoeducation), in which the therapist responded to the question, “Do you think I’ll get better?” by providing the client with concrete educational data regarding typical therapeutic outcomes (See script in Appendix E). The video for group three portrayed the therapist not responding directly to the client’s question, but instead, reflecting the question back to the client in a style consistent with the humanistic tradition (See script in Appendix F). Participants in each group then rated the therapy sessions on measures of breadth of material explored by client (See Appendix G), depth of material explored by client (See Appendix H), and client therapist connectedness (See Appendix I) (the three outcomes desired from successful responses to client questions). Participants also completed a counselor rating measure (See Appendix J). Prior to the assessment of the three outcomes, a manipulation check took place wherein each participant responded to two multiple choice questions to confirm that participants paid attention to the videos, and one multiple choice question that confirmed that participants could identify the therapist’s method for responding to the client’s question (See Appendix K). Finally, each participant was given a debriefing/educational statement regarding the study and a list of available resources should the participant desire services for him/herself (See Appendix L).

**Creation of the videos.** The principle researcher along with her dissertation chair developed the video scripts based on clinical experience. The scripts depict a therapy session that takes place at a college counseling center. The mock client was a first-year college student who is experiencing difficulty adjusting to college life, as well as exhibiting moderate depressive and anxious symptoms (e.g., lack of motivation, general feelings of sadness, sleeplessness). This vignette was created so as to maximize participants' ability to relate to the mock therapy session.

The baseline video script began with a statement by the primary researcher that introduced the vignette to participants and also primed the participants to pay attention to the question that the client will ask approximately 10 minutes into the video as well as the therapist's response to the question (See appendix C). This statement was included in order to increase the likelihood of participants paying attention to the question that the mock client asked as well as the response provided by the therapist. After this introductory statement, the mock therapy session began, depicting the first 10 minutes of a therapy session between the student and the therapist (See Appendix C). In the first condition script, the therapist responded to the client's question at the 10-minute point utilizing Edelstein and Waehler's (2011) four guidelines (See Appendix D). In the second condition script, the therapist responded to the client's question by providing the client with psychoeducation (See Appendix E). In the third condition script, the therapist responded by reflecting the client's question back to the client (See Appendix F). All three videos ended immediately after the therapist provided the response so that the client's subsequent behavior does not bias participants' ratings of the therapist response. The baseline script as well as the three condition scripts were developed with input from three doctoral students in The University of Akron's Counseling Psychology program (as will be described in

greater detail in the next paragraph) in order to ensure that the scripts are representative of an actual counseling session.

Following the development of the scripts, three different doctoral counseling students (who served as independent observers) read the scripts and rated them a 7-point Likert-type scale in terms of how realistic the therapy session appeared, with a score of 1 indicating that the script was not at all realistic and a score of 7 indicating that the script was representative of a counseling session (See Appendix M). All three observers needed to provide ratings of 5 or above in order for the scripts to be validated. Indeed, all three observers provided ratings of 5 or above. In addition, each of the observers needed to correctly identify the type of response the therapist utilized in the script (i.e. 1. Edelstein and Waehler's guidelines, See Appendix N items 1-4; 2. psychoeducation, See appendix N, item 5; 3. reflection, See appendix N, item 6). In order for the scripts to be validated, all three of the doctoral students needed to provide ratings of 5 or above for the item(s) corresponding to the condition script they read. Indeed, all three doctoral students provided ratings of five and above for the items corresponding to the script they read.

Once each of the scripts had been piloted, videos of the scripts were recorded in The University of Akron's Department of Learning Technology and School Services, with both the therapist and the client being portrayed by doctoral counseling students. The actors received the scripts three weeks in advance of the recording in order to become familiar with them, and had rehearsed enacting the scripts together on three separate occasions (for 1 hour each) before the final recording.

## **Measures**

**Demographic questionnaire.** Participants were given a brief demographic questionnaire that included participants' gender, age, race, major, and prior experience in therapy (See Appendix B).

**Session Evaluation Questionnaire-Depth Scale (SEQ-D; Stiles & Snow, 1984).** To assess the first outcome regarding depth of material covered in therapy, this study used form 5 of the Session Evaluation Questionnaire (Stiles & Snow, 1984) (See Appendix H). The SEQ is a self-report measure for rating the effectiveness of therapy sessions on four dimensions (with each dimension containing 5 items): Depth, Smoothness, Positivity, and Arousal (Stiles, 1980; Stiles & Snow, 1984; Stiles, Gordon, & Lani, 2002). Participants were asked to rate only the Depth (SEQ-D) dimension in order to assess outcome one (increased client depth of material covered).

The SEQ-D is a self-report measure for rating the quality of therapy sessions. The stem, "This session was:" is followed by 5 bipolar-adjective-anchored scores that participants rate on a 7-point Likert-type scale. The five items comprising the Depth dimension are valuable-worthless (reverse scored), shallow-deep, full-empty (reverse scored), weak-powerful, and special-ordinary (reverse scored). The SEQ-D is scored by averaging the five items' ratings:  $[(8-\text{worthless}) + (\text{deep}) + (8-\text{empty}) + (\text{powerful}) + (8-\text{ordinary})] / 5$ . Higher total scores indicate greater session depth.

Strong internal consistency has been demonstrated for the SEQ-D. In a study on the relative impact of contrasting time-limited psychotherapies that included 117 clients and a total of 1383 completed SEQs, researchers found a coefficient alpha of  $\alpha=.90$  for the depth dimension (Reynolds, Stiles, Barkham, Sharpio, Hardy, & Rees, 1996). Furthermore, in a study on the interaction between the therapeutic process and the therapeutic alliance during psychological assessment that included 128 clients, a coefficient alpha of  $\alpha=.86$  for the SEQ-D was found

(Ackerman, Hilsenroth, Baity, & Blagys, 2000). These reports exceed Nunnally and Bernstein's (1994) criteria for adequate internal consistency, which was set at  $\alpha=.70$ . The coefficient alpha for the SEQ-D in the current study was .78, which also exceeds Nunnally and Bernstein's (1994) criteria.

Significant correlations have been found between the depth dimension of the SEQ and measures of understanding ( $r=.55$ ,  $p<.001$ ), problem-solving ( $r=.44$ ,  $p<.001$ ), and client-therapist relationship ( $r=.51$ ,  $p<.001$ ) as well as clients' global evaluations of therapy sessions ( $r=.52$ ,  $p<.001$ ), providing evidence of good concurrent validity (Stiles, Reynolds, Hardy, Rees, Barkham, & Sharpio, 1994). In addition, in a post hoc stepwise regression analysis, the depth dimension of the SEQ was found to be a significant, nonredundant, predictor of a measure of clients' global impression of a therapy session ( $r=.77$ ,  $p<.0001$ , Ackerman et al., 2000), further providing evidence of concurrent validity.

**Breadth of material rating.** The researchers for the current study developed a measure to assess the second desired outcome (clients' increased breadth of material covered in therapy), as the researchers do not know of extant measures of this variable (See Appendix G). The measure consisted of three items that participants rated on 7-point Likert-type scales (similar to the SEQ-D). The first item was: "As a result of this session, how likely will the client be to think more broadly about her concerns?" The second item was: "As a result of this session, how likely is it that the client will increase the breadth of her feelings about her concern?" The third item was: "As a result of this session, how likely is it that the client will consider her concerns in a broader context?" Participants rated all three items on a scale from 1 (not likely at all) to 7 (much more likely). An average of these three items yields an overall score ranging from 1 to 7, with higher scores indicating increased breadth of material explored by the client. For the current

study, a coefficient alpha of .86 was computed, which exceeds Nunnally and Bernstein's (1994) criteria for adequate internal consistency ( $\alpha \geq .70$ ).

**Working Alliance Inventory—Observer Form (WAI-O; Horvath, 1981; Horvath & Greenberg, 1986, 1989; Tichenor & Hill, 1989).** To assess outcome 3 (client-therapist connectedness), this study used the Working Alliance Inventory Observer Form (WAI-O) (See Appendix I). The WAI-O is a 36-item Likert-type scale (based on Bordin's [1976] theory of the working alliance) that was developed to assess the working alliance between client and therapist across therapeutic orientations and techniques (Horvath, 1981). The original WAI included both a client form (to be completed by the client) and therapist form (to be completed by a therapist) (Horvath, 1981). Tichenor and Hill (1989) adapted the WAI to serve as an observer-rated form by altering the original pronouns to fit an observer's perspective (e.g., for question 1 of the WAI Client Form, "I feel comfortable with \_\_\_\_\_" was changed to "There is a sense of discomfort in the relationship" in the WAI-O).

The WAI-O contains 3 subscales: goals, tasks, and bond. For the purposes of this study, only the Bond subscale was completed by participants, as this subscale is most closely related to this study's conceptualization of connectedness. According to Bordin's theory of the working alliance, bond refers to the extent to which a client and a therapist feel personal attachment between one another in terms of mutual trust, acceptance, and confidence (1975, 1976, 1980).

The bond subscale of the WAI-O contains 12 items that are observer-rated on Likert-type scales with responses that range from 1 ("never") to 7 ("always"). Thus, the total bond subscale score can range from 12 to 84. Examples of items from the bond subscale include "There is a sense of discomfort in the relationship (reverse scored)," "There is a good understanding



between the client and therapist,” and “The client is aware that the therapist is genuinely concerned for his/her welfare.”

The WAI-O has shown strong internal consistency ( $\alpha=.98$ ) and interrater reliability ( $r=.92$ ) (Tichenor & Hill, 1989). The WAI-O has also shown high concurrent validity with strong intercorrelations with The California Psychotherapy Alliance Scales (Marmar, Gaston, Gallagher, & Thompson, 1987) ( $r=.82, p<.05$ ), the Pennsylvania Helping Alliance Rating Scale (Alexander & Luborsky, 1986; Luborsky, Crits-Cristoph, Alexander, Margolis, & Cohen, 1983) ( $r=.71, p<.05$ ), and the Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983) ( $r=.84, p<.01$ ) (Tichenor & Hill, 1989). For the current study, a coefficient alpha of .90 was computed for the WAI-O bond scale.

**Counselor Rating Form—Short (CRF-S; Corrigan & Schmidt, 1983)** (See Appendix J). In addition to assessing participant’s perceptions of the three desired outcomes (breadth of material explored, depth of material explored, client-therapist connectedness), the researchers believed that collecting data on participants’ overall perception of the counselor’s credibility may be valuable for interpreting results. For example, does perception of counselor credibility vary significantly with the three different therapist responses to the client’s question? If so, does counselor credibility correlate with participants’ perceptions of the three desired outcomes (client’s breadth of material explored, client’s depth of material explored, client-therapist connectedness)? Addressing these questions may provide valuable insight into the results of this study, and also provide implications for future research.

The CRF-S is a revision of the original Counselor Rating Form (CRF; Barak & LaCrosse, 1975; LaCrosse & Barak, 1976), which consisted of 36 7-point Likert-type bipolar adjective scales. The CRF was developed based on Strong’s (1968) interpersonal influence process model,

in which the counselor's objective is to influence the client to achieve the goals of therapy. This counselor "influence," conceptualized as counselor credibility, is directly related to the ability of the counselor to influence the client to make changes toward the goals of therapy, primarily through the communication that takes place within the therapeutic setting. Strong (1968) identified three components of therapist communication that contributes to clients' perceptions of counselors' credibility: *expertness* (counselor's ability to communicate knowledge and skill within the counseling session), *trustworthiness* (counselor's ability to communicate openness, sincerity, and lack of motivation for personal gain), and *attractiveness* (counselor's communication of compatibility and similarity between the counselor and client, which leads to the client's liking of the therapist) (Strong, 1968). Strong (1968) stated that when counselors maximize their communications of expertness, trustworthiness, and attractiveness, they maximize their ability to influence their clients toward therapeutic change.

Barak and LaCrosse (1975) developed the original CRF to measure Strong's (1968) three components of counselor credibility (expertness, trustworthiness, and attractiveness), through factor analysis. Their results supported the three separate components (expertness, trustworthiness, and attractiveness) of counselor credibility in Strong's (1968) interpersonal influence process model. Subsequent studies further supported client's discrimination of the three components of counselor credibility (Barak & Dell, 1977; Barak & LaCrosse, 1977; Kerr & Dell, 1976). In addition, Barack and Lacrosse (1975) found that client's high perceptions of the counselor's expertness, trustworthiness, and attractiveness (as measured by the CRF) positively influenced their therapeutic change.

Corrigan and Schmidt (1983) revised the original CRF, reducing the number of items from 36 to 12. The original CRF consisted of bipolar-adjective 7-point Likert-type scales, with a

positive adjective on the high extreme of the scale (at point 7) and a negative adjective at the low extreme of the scale (point 1). For example, for an item that measures perceptions of the therapist's friendliness, "unfriendly" would be indicated by point 1, and "friendly" would be indicated by point 7. In the CRF-S, the negative adjective was dropped, such that participants simply rate an adjective on a 7-point scale ranging from point 1 ("not very") to point 7 ("very"). For example, for an item that measures perceptions of the therapist's friendliness, "Friendly" would be the item stem, and participants would rate "friendly" from point 1 ("not very") to point 7 ("very"). The elimination of the negative adjectives was intended to increase variance in ratings by minimizing the socially undesirable connotations of the negative adjectives (Corrigan & Schmidt, 1983). The resulting CRF-S consisted of 12 items that alternate between those representing counselor expertness, those representing counselor trustworthiness, and those representing counselor attractiveness. Items within each component (expertness, trustworthiness, and attractiveness) are presented in alphabetical order. Resulting scores range from 4 to 28 for each component.

The 12 items for the short form of the CRF were selected based on their high loading on appropriate dimensions of previous factor analyses (see Barack & LaCrosse, 1975; Zamostny, Corrigan, & Eggert, 1981), and the comprehension level required for understanding the positive adjectives. The resulting measure contained 12 Likert-type items (4 items for each of the components of counselor credibility) that can be comprehended at an 8<sup>th</sup> grade reading level (Corrigan & Schmidt, 1983). Thus, the CRF-S increased the utility of the original CRF by decreasing the amount of time required to complete the measure, by lowering the reading level from a 10<sup>th</sup> grade reading level to an 8<sup>th</sup> grade reading level, and by using only items that had

very high factor loadings from the previous scale (Corrigan & Schmidt, 1983; Epperson & Pecnik, 1985).

In their sample of 133 college students and 155 clients from various community mental health agencies, Corrigan and Schmidt (1983) reported split-half reliabilities for the three components of the CRF-S of .90 for expertness, .87 for trustworthiness, and .91 for attractiveness. In addition, Corrigan and Schmidt (1983) reported that confirmatory factor analyses demonstrated that a 3-factor oblique model, with separate dimensions for expertness, trustworthiness, and attractiveness, provided the best fit for data across the sample of college students and community mental health clients, indicating that the CRF-S indeed, measures three separate components of counselor credibility. Additional confirmatory factor analyses have provided further support for Corrigan and Schmidt's original supposition that the CRF-S measures the three independent components (expertness, trustworthiness, and attractiveness) of counselor competency (Epperson, & Pecnik, 1985; Tracey, Glidden, & Kokotovic, 1988).

Although such confirmatory factor analyses have demonstrated that each dimension of the CRF-S measures a different component of counselor competency (expertness, trustworthiness, and attractiveness), high intercorrelations have been found between the three components (Constantine, 2002; Fuertes & Brobst, 2002; Guinee & Tracey, 1997; Harari & Waehler, 1999; Kokotovic & Tracey, 1987; Tracey et al., 1988), suggesting that the CRF-S may be used as a global rating of counselor competency. The current study used the total CRF-S score. A coefficient alpha of .97 was computed for the current sample.

## **Results**

First, collected data were screened for failure to pass the manipulation check, missing values, outliers, influential data points, and departures from assumptions underlying between-

subjects, one-factor MANOVA tests (including multivariate normality and homogeneity of covariance matrices), as well as for departures from assumptions underlying between-subjects one-way ANOVA tests (including normality and homogeneity of variance) (Pedhazur & Schmelkin, 1991; Tabachnick & Fidell, 2001; 2007). The data did not depart from the assumptions underlying between-subjects, one-factor MANOVA tests or between-subjects, one-way ANOVA tests. Ninety-five participants passed question three of the manipulation check (19 for condition 1; 33 for condition 2; and 43 for condition 3), which asked participants to identify how the therapist responded to the client's question. As this number was not adequate to yield sufficient power, the data were analyzed twice: once for all participants who completed the study ( $N = 138$ ), and then again for only those participants who passed the manipulation check ( $n = 95$ ) to see if results differed significantly.

Descriptive statistics were calculated (i.e. means, standard deviations) for both demographic variables (see "Participants" section; See Table 1) and the dependent variable measures (Breadth of Material Rating, SEQ-D, WAI-O, and CRF-S; See Table 5). The mean SEQ-D score for all participants was 4.26 ( $SD = 1.03$ ); the mean Breadth Score for all participants was 4.68 ( $SD = 1.21$ ); the mean WAI-Bond score was 5.27 ( $SD = 1.01$ ), and the mean CRF score was 5.0 ( $SD = 1.39$ ). Participants who had attended counseling previously demonstrated significantly lower ratings on the Breadth scale ( $f = 4.178$ ;  $p = .043$ ) than those

**Table 5**

*Dependent Measures Descriptive Statistics by Group*

Measure	Condition 1			Condition 2			Condition 3			All		
	n	M	SD	n	M	SD	n	M	SD	N	M	SD
SEQ-D	47	4.2	1.0	45	4.3	1.2	46	4.2	1.0	138	4.3	1.0
Breadth	47	4.6	1.2	45	4.8	1.1	46	4.6	1.3	138	4.7	1.2
WAI-Bond	47	5.3	1.0	45	5.4	1.0	46	5.2	1.1	138	5.3	1.0
CRF	47	4.9	1.5	45	5.2	1.3	46	4.9	1.3	138	5.0	1.4

**Table 6***Correlations of Dependent Measures*

Measure	1	2	3
1. SEQ-D			
2. Breadth	.44**		
3. WAI-Bond	.62**	.59**	
4. CRF	.66**	.61**	.80**

*Note.* \*\* $p < .01$

who had not been to counseling, and age was significantly and negatively correlated with the WAI-Bond ( $r = -.20$ ;  $p = .02$ ) and the CRF ( $r = -.23$ ;  $p = .008$ ). A Pearson's Chi Square revealed that participants' counseling experience varied consistently between groups ( $p = .390$ ), and an ANOVA with condition entered as the group variable and age entered as the dependent variable demonstrated that age did not differ significantly between groups ( $F = 2.99$ ;  $p = .054$ ). Thus, neither counseling experience nor age was entered as a covariate in the main analyses. Participants did not differ significantly in their ratings of the dependent measures by any other demographic variables.

Next, hypothesis testing took place (H1: The video in which the therapist utilized Edelstein and Waehler's guidelines will produce significantly higher ratings on all three of the measures than the video in which the therapist utilized reflection; H2: The video in which the therapist utilized Edelstein and Waehler's guidelines would produce significantly higher ratings on all three of the measures than the video in which the therapist utilized psychoeducation). To determine whether there was an overall difference between observer ratings of the client's depth of material explored, breadth of material explored, client-therapist connectedness, and perceptions of counselor competency between the three conditions (i.e. therapist responds using Edelstein and Waehler's guidelines, psychoeducation, or reflection), two different one-way,

between subjects MANOVAs were performed—one for the total number of participants ( $N = 138$ ) and one for only those participants who correctly responded to the manipulation check ( $n = 95$ ; See Table 7). The MANOVA using all 138 participants' data (where condition served as the group variable, and the SEQ-D, the Breadth Measure, the WAI-O, and the CRF served as the dependent variables) produced non-significant results (Wilks'  $\lambda = .980$ ,  $F(8, 264) = .339$ ,  $p = .95$ ), indicating that there was no overall difference between the three groups on any of the measures for the total number of participants ( $N = 138$ ). When the MANOVA was re-run using data from only those participants who passed the manipulation check ( $n = 95$ ), results remained insignificant (Wilks'  $\lambda = .946$ ,  $F(8, 178) = .628$ ,  $p = .75$ ), indicating that again, there was no difference between the three groups on any of the measures used. As neither of the MANOVAs were significant, there was no need to run post-hoc analyses to determine the significance of each measure individually.

**Table 7**

*MANOVA—Differences in Perceived Session Depth, Breadth, Client-Therapist Connectedness, and Therapist Competence Between Therapist Response Conditions*

Variable	Wilks' $\lambda$ Value	F	df	p	Partial eta squared
Condition ( $N = 138$ )	.98	.34	8	.95	.01
Condition ( $n = 95$ )	.95	.63	8	.75	.03

## Discussion

The current study set out to examine a largely neglected area of research within the counseling psychology literature: how to best respond when clients ask direct questions of the therapist. A set of four guidelines for responding to clients' questions (receiving the question respectfully, promoting clients' curiosity about the question, answering the question sufficiently, and exploring possible underlying/idiosyncratic meanings of the question) outlined by Edelstein

and Waehler (2011) were examined alongside two other methods for responding to client questions (responding with psychoeducation; responding by reflecting the question back to the client) to determine whether utilization of the guidelines resulted in views of the therapeutic process different from these other two responses.

This study employed an analogue design where participants (undergraduate psychology students) rated videos of a mock therapy session in which the therapist responded to the client's question ("Do you think I'll get better?") in one of three ways: utilizing Edelstein and Waehler's guidelines; utilizing psychoeducation; reflecting the question back to the client. Participants then rated the videos on measures of depth of perceived client exploration (measured using the Session Evaluation Questionnaire-Depth Scale), breadth of perceived client exploration (measured using the Breadth Measure), perceived client-therapist connectedness (measured using the Working Alliance Inventory-Bond Scale), and perceived therapist competence (measured using the Counselor Rating Scale). Participants' age, gender, race, college major, and prior counseling experience were also recorded for possible covariates.

Data were examined for significant interactions between the demographic variables and the dependent variables, as well as for violations of test assumptions. Participants who had attended counseling previously demonstrated significantly lower ratings of perceived breadth of material explored by the client compared to those participants who had never attended counseling, and age was significantly and negatively correlated with perceptions of client therapist connectedness as well as perceived therapist competence, such that older participants tended to rate the client and therapist as having a worse connection and perceived the therapist as being less competent than younger participants. As follow-up analyses (Pearson's Chi Square and a one-way, between subjects ANOVA) determined that participants' counseling experience



and mean age did not vary significantly between the three conditions, neither were entered as covariates in the main analyses. Significant violations of other test assumptions were not found.

For the main analyses, two one-way, between-subjects MANOVAs were conducted (one for all 138 participants, and one for only those who correctly responded to the manipulation check;  $n = 95$ ) to determine whether participants perceived the quality of the mock therapy session differentially between groups. Results showed that participants' mean ratings of perceived client depth of material explored, perceived client breadth of material explored, perceived client-therapist connectedness, and perceived counseling competency did not differ significantly between the three conditions. In other words, the way in which the therapist in the video responded to the client's question did not appear to significantly alter participants' perceptions of the client's ability to think about her concerns more deeply or broadly, nor did it appear to affect participants' perceptions of client-therapist connectedness or the therapist's competence.

The non-significant findings in the current study indicate that, with regard to the videos the participants viewed, the ways in which the therapist responded to the client's question did not make a difference in observers' perceptions of the quality of this short excerpt from a therapy session. In fact, the results of this study indicate that participants in all three conditions considered the session they watched to be about equally successful, regardless of the type of response the therapist used in the last interaction viewed. The items in all four measures were rated on 7-point Likert-type scales, and the mean rating in all three conditions were consistently rated at 4.2 or above for all measures, which approaches a full point higher than what would be a neutral rating of 3.5. Thus, participants seem to have viewed all three of the therapist's responses to be helpful in their own ways.

Generalizing these observers' responses to an actual therapeutic context, the results of the current study suggest that therapists who respond to their clients' questions using either Edelstein and Waehler's guidelines, psychoeducation, or reflection may be experienced as equally effective by their clients. Although client questions have been found to result in anxiety for clinicians (i.e. Chakraborti, 2006; Edelstein & Waehler, 2011), this study's results suggest that therapists may be more cognizant than their clients of the impact their responses to questions may have on the therapeutic process. If this is the case, the findings in the current study could give clinicians (particularly novice clinicians) peace of mind, as clinicians' various responses to clients' questions may not significantly alter the clients' overall exploration of material, the therapeutic bond, or the clinicians' perceived competence.

Despite the apparent finding that the manipulation of the therapist's response to the client's question did not affect participants' overall ratings of the mock therapy session, we could generate some minor explanations for how the study's methodology contributed to the non-significant findings. For instance, the single manipulation that differentiated the conditions may have lacked a potency to influence the overall ratings of the client session. All participants viewed the same 10 minute video with only the last 5-30 seconds (where the therapist responded to the client's question) differing between the three. This may not have been enough of a manipulation to produce significantly different perceptions of the counseling session. In other words, the client's question and the therapist's responses may not have stood out enough for participants (as the lack of ability of participants to differentiate between conditions in the manipulation check would suggest); thus, it is possible that the participants based their ratings on the entire 10-minute video—not just the last interaction.

The non-significant results in the current study could also be an artifact of the participant population. Participants were undergraduate psychology students who participated in the study in order to earn extra credit points. They needed only to view the videos and to fill out the questionnaires in order to receive extra credit points in their classes. Thus, these students may not have been invested enough in the study to pay sufficient attention to the video, or to fill out the questionnaires thoughtfully enough to produce significant findings. Indeed, only 96 of the 138 participants responded accurately to the manipulation check, indicating that a large portion of students did not attend fully to the videos they viewed (although this idea is counterindicated by the overall quality of participants' responses; i.e. the vast majority of participants responded to reverse-scored items consistently).

It is also possible that a mismatch between the content of the videos and the content of the measures confounded the results of the current study. As they completed the various measures, several participants made comments to the primary researcher that it was difficult to answer many of the items as the videos did not address relevant issues that would enable them to make informed responses. For example, the primary researcher received several questions about number 13 of the WAI, which read "There is agreement about what the client's responsibilities are in therapy" as well as number 22 of the WAI, which read "The client and therapist are working on mutually agreed upon goals." Indeed, the videos did not address these issues, and participants truly did not have adequate information to make informed ratings (although these particular items were not included in the final analyses, as they were not a part of the WAI-Bond subscale, it is possible that participants generalized a belief that they did not have sufficient information to complete these items to the entire questionnaire, and thus, did not put sufficient thought into their ratings). In addition, several participants asked the primary researcher what

was meant by several of the items on the SEQ, such as item 7, “full vs. empty” and item 10, “rough vs. smooth.” Other participants may have also been confused about the meaning behind these and other items, but did not ask the researcher (e.g. out of embarrassment; they did not care about their responses). Several participants also asked the primary researcher if they were expected to fill out the measures with regard to the video they had just watched or with regard to their personal views of how a counseling session should take place (despite instructions to fill out the measures in response to the video). It may be that other participants had similar questions but did not voice them, and thus assumed that they were supposed to complete the measures based on their own views of counseling. Lastly, one participant wrote on the top of the WAI, “It’s hard to know with actors,” indicating that the participant found it difficult to rate the client-therapist connectedness based on the actors’ portrayal of the therapy session. Other participants may have had similar feelings, which would suggest that the analogue design used in the current study was not an ideal method of measuring the perceived helpfulness of therapists’ responses to client questions.

The analogue design used in the current study could have contributed to the non-significant findings in other ways as well. As the current study employed a simulation of a therapy session (rather than an actual therapy session), and used participants’ observations as data (rather than actual clients’ experiences), it cannot be known if the ways in which therapists respond to client questions would make a difference in an authentic therapeutic setting. It may not be possible to adequately assess the effects of responding to client questions by measuring observers’ ratings at all; rather, it may be that an authentic human encounter is required for effects of responding effectively to client questions to be experienced. Alternatively, actors in the

study may not have portrayed a therapy session authentically enough to simulate the experience of being in an actual therapeutic dialogue.

Since one intention of the current research was to speculate about the truthfulness of research in this area, the following sections will offer some concrete directions that may help guide future research. In order to address the concern that the manipulation was too subtle (in that the only difference between the three videos was the last 10 to 30 seconds where the therapist responded to the client's question), future studies may try infusing several questions within a mock therapy session, where the therapist consistently responds to the client's questions using Edelstein and Waehler's (2011) guidelines, psychoeducation, or reflection. Such a change would also allow for different types of questions to be asked (i.e. requests for therapist self-disclosure; questions about the logistics of therapy), which may result in more differentiated observations by participants.

Several suggestions for future research can also be made to increase the validity of participants' responses based on the feedback from the participants in the current study. First, in order to address the comments that the videos did not address issues that would allow participants to respond to the items in the measures knowledgeably, future researchers would do well to create a video that more closely mirrors the items in the measures so that there is greater continuity between the video and the measures, making it easier for participants to make informed ratings of the items. In response to the concern that participants may not have voiced their confusion regarding what was meant by certain items in various measures (e.g. items 7 and 10 of the SEQ-D), it may be helpful for future researchers to explicitly include a directive, in both written and verbal instructions, for participants to ask the researcher about any and all confusions they have regarding the items in the measures. Finally, to address the question many

participants had regarding whether they were supposed to fill out the questionnaires with regard to the video or with regard to their own conceptions of how therapy should be, it may be beneficial to make instructions even more explicit in directing participants to fill out measures with regard to their perceptions of the video (i.e. reiterating this directive in the instructions for each measure; manually handing participants one measure at a time, and in doing so, verbalizing the directive with each measure) and in particular, with regard to the last segment viewed.

Recognizing that the video session depicted in the current study yielded non-significant results, future research in this area would do well to move beyond the analogue design used in this study and use other methodologies to replicate or refute these findings. To this end, a qualitative method may be fruitful for future studies to measure participants' perceptions of therapists' responses to client questions overtly. This could be achieved through a direct discussion about participants' perceptions of how responses to their questions could help or hinder their exploration of thoughts and emotions; specifically, participants could be questioned directly about how they would experience a therapist who responded to a question they had by using: 1) Edelstein and Waehler's guidelines, 2) psychoeducation, or 3) reflection. The researcher could provide participants with specific examples of each of these types of responses, and then interview participants directly about their perceptions of how the therapist's response could make them consider their concerns in broader or deeper ways and how/if the response would affect their feelings of connectedness with the counselor. An additional benefit to this design could be that researchers would gain more in-depth information about participants' perceptions of therapists' various responses, including the quality of the responses in relation to the outcome criteria specified as well as the overall session quality.

Alternatively, overtly assessing participants' perceptions of a therapist's response could be achieved using quantitative methods, where participants would respond to multiple-choice questions that ask, for example, "Which therapist response to this client's question would enable the client to examine her concerns in a deeper context?" Participants could then choose from a list of potential responses that have varying levels of response material. The same type of question/response format could be repeated for questions regarding perceptions of breadth, therapist-client connectedness, and therapist competence. One advantage to both the qualitative and quantitative strategies suggested here is that this research could be conducted with actual clients or potential (wait-listed) clients, which would produce results that could be generalized more easily to actual clients' experiences compared to analogue designs using non-clinical populations.

Future studies may also do well to employ experimental designs that address the concern that the effects of responding to clients' questions in various ways can only be assessed within an authentic therapeutic encounter. Such a design could involve comparing the therapeutic outcomes of actual therapy sessions (i.e. depth of sessions, therapeutic bond, symptom relief) of both therapists who have been trained in utilizing Edelstein and Waehler's guidelines in session and those who have not. As such a design would take place in an authentic therapeutic context, the results would be more meaningful in terms of being generalizable to other real-world therapeutic contexts and would answer the out-standing question of whether effects of responding to client questions can only be assessed within an actual therapeutic encounter.

In addition, process research could be a fruitful endeavor for assessing the ways in which therapists' responses to clients' questions affect important outcomes within an authentic therapeutic setting. Following each session, clients could be interviewed about the ways in which

their interactions with the therapist (with a specific emphasis on the ways in which therapists responded to clients' questions) affected their experiences in therapy. Researchers could collect both qualitative data (i.e. through interviewing clients about their perceptions of the therapist; specifically, if and how he/she responded to clients' questions), as well as quantitative data (e.g. measuring the clients' perceptions of client-therapist connectedness after each session using the Penn Helping Alliance Scales; Luborsky, Barber, Siqueland, Johnson, Najavits, Frank, & Daley, 1996), thereby obtaining a more holistic account of clients' therapeutic experiences. Changes in the clients' perceptions of the impact of each therapy session could then be related to specific therapeutic events, particularly therapists' responses to clients' questions.

Lastly, utilizing correlational research methods that examine archival data (e.g. video-taped therapy sessions; transcribed therapy sessions) may add significantly to the extant literature on client questions and therapists' responses. Such research could correlate the ways in which therapists respond to clients' questions with other therapeutic activities and clinical outcomes. Such an examination of archival data would also be useful for creating a typology of questions clients ask (as well as correlating the number and types of questions clients ask with client characteristics such as age, level of education, etc) and a typology of responses therapists tend to give, which would be valuable in guiding future research endeavors in this area.

Although the current study did not generate statistically significant findings, the focus taken draws attention to an area often neglected in clinical practice: how best to respond when clients ask questions. Practitioners may do well to consider the ways in which their responses to clients' questions serve the therapeutic process optimally. Examining research and theory in the area of client questions (and related areas such as therapist self-disclosure), may help to prepare



practitioners for the questions their clients ask, subverting the feeling of being “caught off-guard” that is so common in such situations (Edelstein & Waehler, 2011).

The current study was the first of its kind to examine perceptions of a therapy session based on the ways in which a mock therapist responded to a mock client’s question. Although findings were non-significant, the current study has laid the groundwork for future studies in this area of research to find answers to that common wondering: “How should I respond when my client asks me a question?”

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## Appendix A: Informed Consent

### Responding to Client Questions

You are invited to participate in a research project being conducted by Natalie Grandy, a doctoral student in the Department of Psychology at The University of Akron.

The purpose of this study is to assess the perceived impact of therapist interaction with a client. This study will involve approximately (120) participants.

Your participation in this study will consist of your completion of a brief demographic questionnaire, followed by viewing a brief video (lasting approximately 10 minutes) depicting a mock therapy session between a college student and a therapist. You will then be asked to complete four questionnaires regarding your perceptions of the mock therapy session, followed by a questionnaire regarding specific aspects of the video (for a total of 5 post-video questionnaires). The entire duration of your participation should last approximately 1 hour.

In order to be eligible for participation in this study, you must be at least 18 years old and currently enrolled as a student at The University of Akron.

The video of the counseling session that you will be asked to watch portrays a college student who is suffering from moderate depressive and anxious symptoms. Viewing such a video may result in mild discomfort. You will be provided with a list of referrals should you desire counseling assistance.

The benefits to you for participating in this study may be that you learn about the counseling process, and thus, you may feel more comfortable seeking counseling services should you ever desire them. Although we cannot guarantee that you will receive any benefits, your participation in this study may help us to better understand how counselors can respond to clients in ways that enhance the therapeutic process.

You will receive 4 extra credit points in your psychology class for your participation in this study through the Human Participation in Research (HPR) system.

Participation in this study is voluntary. Refusal to participate or your decision to withdraw from this study at any time will in no way affect your grade. You may discontinue your participation in this study at any time without prejudice or explanation.

Any identifying information collected will be kept in a secure location and only researchers will have access to the data. Your signed informed consent form will be kept separate from all of your responses and will be kept under a double lock. These forms will be kept stored for the required five year period before being disposed of by shredding. Individual participants will not be identified in any publication or presentation of the research results. Only aggregate data will be used.

If you have any questions about this study, you may contact Natalie Grandy at 330-972-7280 (nmg35@uakron.edu) or Dr. Charles Waehler at 330-972-6701 (cwaehler@uakron.edu). This project has been reviewed and approved by The University of Akron Institutional Review Board. If you have any questions about your rights as a research participant, you may call the IRB at (330) 972-7666.

I have read the information provided above and all of my questions have been answered. I voluntarily agree to participate in this study. I will receive a copy of this consent form for my information.

---

Participant Signature

---

Date

## Appendix B

## Demographic Questionnaire

1. What is your sex? (please circle one)

Male

Female

Transgender

Other

2. What is your age? \_\_\_\_\_

3. What is your race? (please circle one)

African American

American Indian/Alaska Native

Asian American

Native Hawaiian or Other Pacific Islander

Hispanic/Latino American

White/Caucasian American

Biracial/Multiracial \_\_\_\_\_ (Please Specify)

Other \_\_\_\_\_ (Please Specify)

4. What is your major in college? \_\_\_\_\_

5. Have you been to counseling/therapy before? (please circle one)

Yes

No

## Appendix C

## Baseline Video Script

*Introduction:*

**Primary Researcher:** Thank you very much for participating in this study regarding therapist-client interactions. You are about to view a video of a mock therapy session. Toward the end of the video, about twelve minutes in, the mock client will ask the mock therapist a question. We ask that you pay attention to this question and the therapist's response to the question. Again, thank you very much for your participation.

*Cut to therapy session:*

**Counselor:** Well Karen, since last time I saw you was our first session, and we had a lot of kind of "housekeeping" things to go over, we really only had the chance to scratch the surface of your concerns.

**Karen:** Definitely...I don't even know where to start with everything...

**Counselor:** Well, we talked a little bit about some of your concerns as far as adjusting to your first semester at college here, so why don't you tell me how this past week went for you.

**Karen:** Um...it was okay; about the same I guess. I had a test in history, and I don't think I did very good on it. I always used to get really good grades in high school, but I just can't seem to think straight here...like no matter how much I study, the information just doesn't stick.

**Counselor:** So high school seemed to come a lot easier for you than college does now.

**Karen:** Yea, and I don't know why. I mean, it's definitely more work, but there just seems to be so much other stuff to think about.



**Counselor:** I'm hearing you say that college is a lot more challenging kind of, in an academic sense, than anything you've experienced before...it sounds like there is so much other stuff that you can't seem to focus on classes; is that right?

**Karen:** Yea...I guess so...I mean, when I was home, you know, I didn't have to worry about a lot of stuff. Like, I could study in my bedroom if I needed quiet, and I could grab something from the kitchen if I was hungry. No problem. Now, it's just uncomfortable. I mean, it's really different in the dorms. My roommate Jill is okay, but we just haven't clicked, you know, and I always feel uncomfortable just studying in the room when she's there because the silence feels weird. And like...if I'm hungry, I have to go to the cafeteria, and that's always weird because everyone already has like a ton of friends, and I just sit by myself like a loser. Jill has her friends, and she hasn't invited me to sit with them or anything. I don't know...

**Counselor:** It sounds like you're feeling a little lonely.

**Karen:** I guess I am. I do miss my friends back home. We all went to different schools, and they're all busy, and we never talk. I miss my family too. Every time I talk to them I just end up crying and that sucks because then they get worried about me and I don't want them to worry about me, but I just miss them so much, and I don't have anyone to talk to here.

**Counselor:** You mentioned that you cry a lot when you're on the phone with your family; do you find yourself crying at other times?

**Karen:** Oh yea. Like weekends are really hard. I can hear people down the hall having fun and laughing, and there I am, just sitting in my dorm doing nothing; but if I was home, I could be out with my friends, or whatever.

**Counselor:** So do you think the reason you haven't been real happy here is because you're feeling lonely?

**Karen:** I mean, yea...like, at home, even if my friends are busy or whatever, I can hang out and have dinner with my parents, or go out for coffee and run into people that I know and stuff like that.

**Counselor:** You can't just go out for coffee here?

**Karen:** I guess I could...I don't know; I don't really know where I could even go for coffee, and I don't know if people will be cool there, and I don't know...it's like, I hate sitting alone in the dorm, but it just seems like too much to go out.

**Counselor:** Too much?

**Karen:** Yea, it's like, I'm too tired or something, you know? Like, I have to drag myself out of bed to make it to class on time, and when I get back, it seems too hard to leave again. I just feel drained. I mean, even if I had somewhere to go or someone to hang out with, I wouldn't be fun. I'd just be like a blob. *I* wouldn't want to hang out with me.

**Counselor:** Wow...it sounds like you're really stuck between a rock and a hard place. You're not happy sitting at home, but you're too tired to go out.

**Karen:** Yea...

**Counselor:** So what do you do?

**Karen:** I just sit...if there's something good on TV I'll watch that. Sometimes I try to study, but that takes too much energy. Sometimes I feel like calling my parents, but then I think I'll just feel worse because I know I'll just miss them more; sometimes I just eat because there's nothing else to do, which, you know, makes me feel worse, because I'm already putting on weight.

**Counselor:** It sounds like you're spending a lot of time by yourself just feeling sad.

**Karen:** Exactly; and I mean, I *could* try to hang out with my roommate or something, but I just feel really self-conscious. Like, I don't feel like myself, and I don't know what other people must

think of me, so like, even if my roommate's around, I'm not alone anymore obviously, but then I always feel like I need to say something, or seem like more fun than I am or something; it's just really uncomfortable.

**Counselor:** Has it always been that way? I mean, have you always felt self-conscious like that?

**Karen:** Not at all! I used to have a lot of friends, and I was fun to be around, and the things I wanted to say came out right and all of that. I just feel like I've lost a part of that...like I've lost part of me.

**Counselor:** Lost a part of you...that must feel really scary.

**Karen:** It is. I don't know what's wrong with me. I mean, I can't study, I can't sleep, I haven't made friends...I mean, one of the reasons I wanted to live in the dorms was because of the floor activities and stuff, but I haven't even been to any...I just feel too scared to.

**Counselor:** Wow...what do you think changed between then and now?

**Karen:** Hmm...I don't know. I mean I've gone through a lot of changes, but I don't know why any of them would make me feel this way.

**Counselor:** Can you tell me about some of those changes?

**Karen:** Sure, I mean moving here, for sure...starting college, being away from my friends, not having my family nearby, teachers expect a lot more out of you than they did in high school, I don't have a job right now, so I'm living off of my student loans and money from my parents, which makes me feel guilty.

**Counselor:** Wow...that is a lot of change for someone to go through in the course of just a couple of months!

**Karen:** Yea...I guess it is...

**Counselor:** You mentioned that you feel guilty about living off of your parents money and student loans...what do you mean by that?

**Karen:** I mean, here I am, feeling this way, and my parents have put so much into me being here...I should be happier. I mean, what if coming here was a mistake and now my parents have put so much into it, and I'm just not meant to be here?

## Appendix D

## Response Using Guidelines Script

**Counselor:** So you're wondering if college just isn't for you, but you feel like if you were to leave, you'd be letting down your parents.

**Karen:** Yea. I know they just want me to be happy, and I feel bad because they've tried to make me happy here, but I'm worried that this isn't right for me. I mean, I don't exactly know what I want to major in, but if I drop out, I won't be able to get a job anywhere...I mean, it's not enough to just have a high school diploma anymore, you know? I just don't know. Part of me just feels like I wish things could just be like they used to be.

**Counselor:** Like they used to be?

**Karen:** Yea, like I used to be excited about stuff, and I'm not now. I used to have the energy to get out and jog, and I haven't done that in forever—it just seems like, what's the point, you know? I don't know; I just feel so stuck in a rut.

**Counselor:** It sounds like life felt effortless for you before, and now things have changed, and all of a sudden, everything is more complicated.

**Karen:** Yes...everything. I mean, even just getting up in the morning is more complicated. I feel so useless.

*Silence*

**Karen:** Do you think I'll get better?

**Counselor:** Well, that's a really great question, Karen, and I think it speaks to how much you want things to be like they used to be. (pause) You know, I think that by coming here, you have already begun to deal with these concerns differently and that can be really helpful when you feel so stuck in a rut. Plus, there is a whole lot of research out there that says that coming to therapy

like this can really help people in situations just like yours to feel better. What do you think getting better will look like for you?

## Appendix E

## Response Using Psychoeducation Script

**Counselor:** So you're wondering if college isn't for you, but you feel like if you were to leave, you'd be letting down your parents.

**Karen:** Yea. I know they just want me to be happy, and I feel bad because they've tried to make me happy here, but I'm worried that this isn't right for me. I mean, I don't exactly know what I want to major in, but if I drop out, I won't be able to get a job anywhere...I mean, it's not enough to just have a high school diploma anymore. I just don't know. Part of me just feels like I wish things could just be like they used to be.

**Counselor:** Like they used to be?

**Karen:** Yea, like I used to be excited about stuff, and I'm not now. I used to have the energy to get out and jog, and I haven't done that in a long time—it just seems like, what's the point, you know? I don't know; I just feel so stuck in a rut.

**Counselor:** It sounds like life felt effortless for you before, and now things have changed, and all of a sudden, everything is more complicated.

**Karen:** Yes...everything. I mean, even just getting up in the morning is more complicated. I feel so useless.

*Silence*

**Karen:** Do you think I'll get better?

**Counselor:** Well Karen, research shows that most people who go to therapy do get better—sometimes that means they just feel happier, sometimes it means that they learn to act in different ways, and sometimes it just means that they learn to think about things in more positive ways. *(pause)* Based on that, I'd say chances are really good that you'll get better...if you want, I

can bring in a couple of articles for you to read that talk about how effective therapy really can be.



## Appendix F

## Response Using Reflection Script

**Counselor:** So you're wondering if college isn't for you, but you feel like if you were to leave, you'd be letting down your parents.

**Karen:** Yea. I know they just want me to be happy, and I feel bad because they've tried to make me happy here, but I'm worried that this isn't right for me. I mean, I don't exactly know what I want to major in, but if I drop out, I won't be able to get a job anywhere...I mean, it's not enough to just have a high school diploma anymore. I just don't know. Part of me just feels like I wish things could just be like they used to be.

**Counselor:** Like they used to be?

**Karen:** Yea, like I used to be excited about stuff, and I'm not now. I used to have the energy to get out and jog, and I haven't done that in a long time—it just seems like, what's the point, you know? I don't know, I just feel so stuck in a rut.

**Counselor:** It sounds like life felt effortless for you before, and now things have changed, and all of a sudden, everything is more complicated.

**Karen:** Yes...everything. I mean, even just getting up in the morning is more complicated. I feel so useless.

*Silence*

**Karen:** Do you think I'll get better?

**Counselor:** So you are wondering if you will ever get better.

## Appendix G

## Breadth of Material Rating

For this measure, please rate how broadly the mock client will consider her concerns as the result of her counseling session. By “*broadly*,” (as seen in question 1), “*breadth*,” (as seen in question 2), and “*broader*” (as seen in question 3), we mean the extent to which the client is able to extend her range of thoughts, emotions, and feelings).

1. As a result of this session, how likely will the client be to think more *broadly* about her concerns?

1	2	3	4	5	6	7
Not likely at all						Much more likely

2. As a result of this session, how likely is it that the client will increase the *breadth* of her feelings about her concerns?

1	2	3	4	5	6	7
Not likely at all						Much more likely

3. As a result of this session, how likely is it that the client will consider her concerns in a *broader* context?

1	2	3	4	5	6	7
Not likely at all						Much more likely

## Appendix H

## Session Evaluation Questionnaire

## Session Evaluation Questionnaire (Form 5)

ID# \_\_\_\_\_

Date: \_\_\_\_\_

***Please circle the appropriate number to show how you feel about this session.***

**This session was:**

bad	1	2	3	4	5	6	7	good
difficult	1	2	3	4	5	6	7	easy
valuable	1	2	3	4	5	6	7	worthless
shallow	1	2	3	4	5	6	7	deep
relaxed	1	2	3	4	5	6	7	tense
unpleasant	1	2	3	4	5	6	7	pleasant
full	1	2	3	4	5	6	7	empty
weak	1	2	3	4	5	6	7	powerful
special	1	2	3	4	5	6	7	ordinary
rough	1	2	3	4	5	6	7	smooth
comfortable	1	2	3	4	5	6	7	uncomfortable

## Appendix I

## Working Alliance Inventory—Observer Form

**1. There is a sense of discomfort in the relationship.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**2. There is agreement about the steps taken to help improve the client's situation.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**3. There is concern about the outcome of the sessions.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**4. There is agreement about the usefulness of the current activity in therapy (i.e., the client is seeing new ways to look at his/her problem).**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**5. There is good understanding between the client and therapist.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**6. There is a shared perception of the client's goals in therapy.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**7. There is a sense of confusion between the client and therapist about what they are doing in therapy.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**8. There is a mutual liking between the client and therapist.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**9. There is a need to clarify the purpose of the sessions.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**10. There is disagreement about the goals of the session.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**11. There is a perception that the time spent in therapy is not spent efficiently.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**12. There are doubts or a lack of understanding about what participants are trying to accomplish in therapy.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**13. There is agreement about what client's responsibilities are in therapy.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**14. There is a mutual perception that the goals of the sessions are important for the client.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**15. There is the perception that what the therapist and client are doing in therapy is unrelated to the client's current concerns.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**16. There is agreement that what the client and therapist are doing in therapy will help the client to accomplish the changes he/she wants.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**17. The client is aware that the therapist is genuinely concerned for his/her welfare.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**18. There is clarity about what the therapist wants the client to do.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**19. The client and the therapist respect each other.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**20. The client feels that the therapist is not totally honest about his/her feelings toward her/him.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**21. The client feels confident in the therapist's ability to help the client.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**22. The client and therapist are working on mutually agreed upon goals.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**23. The client feels that the therapist appreciates him/her as a person.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**24. There is agreement on what is important for the client to work on.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**25. As a result of these sessions there is clarity about how the client might be able to change.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**26. There is mutual trust between the client and therapist.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**27. The client and therapist have different ideas about what the client's real problems are.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**28. Both the client and therapist see their relationship as important to the client.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**29. The client fears that if he/she says or does the wrong things, the therapist will stop working with him/her.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**30. The client and therapist collaborated on setting the goals for the session.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**31. The client is frustrated with what he/she is being asked to do in the therapy.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**32. The client and therapist have established a good understanding of the changes that would be good for the client.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**33. The therapy process does not make sense to the client.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**34. The client doesn't know what to expect as the result of therapy.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**35. The client believes that the way they are working with his/her problem is correct.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

**36. The client feels that the therapist respects and cares about the client, even when the client does things the therapist does not approve of.**

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

## Appendix J

## COUNSELOR RATING FORM-S

On the following pages, each characteristic is followed by a seven-point scale that ranges from “not very” to “very.” Please indicate the number at the point in the scale that best represents how you viewed the counselor on the video recording.

## Friendly

1	2	3	4	5	6	7
not very						very

## Experienced

1	2	3	4	5	6	7
not very						very

## Honest

1	2	3	4	5	6	7
not very						very

## Likeable

1	2	3	4	5	6	7
not very						very

## Expert

1	2	3	4	5	6	7
not very						very

## Reliable



1	2	3	4	5	6	7
not very						very

Please circle the number at the point in the scale that best represents how you viewed the counselor on the video recording.

Sociable						
1	2	3	4	5	6	7
not very						very

Prepared						
1	2	3	4	5	6	7
not very						very

Sincere						
1	2	3	4	5	6	7
not very						very

Warm						
1	2	3	4	5	6	7
not very						very

Skillful						
1	2	3	4	5	6	7
not very						very

Trustworthy						
1	2	3	4	5	6	7
not very						very

## Appendix K

## Manipulation Check

1. In the video, the client was going to counseling for:
  - A.) Relationship trouble
  - B.) Trouble adjusting to college
  - C.) Trouble at work
2. The client in the video made many new friends since starting college
  - A.) True
  - B.) False
3. The best way to describe the therapist's response to the client's question, "Do you think I'll get better?" is
  - A.) The therapist respectfully received the question, answered the question, and explored the meaning and context of the question.
  - B.) The therapist provided the client with information that research indicates about the benefits of therapy.
  - C.) The therapist restated this question back to the client.

## Appendix L

## Debriefing Form

Thank you for your participation in this study, *Responding to Client Questions*. Therapy is an interpersonal process in which it is important to pay attention to what is said in order to promote optimal personal growth. Your participation in this study has provided us with important information regarding how therapeutic growth is perceived by interested observers in response to a therapist's response to a client's question.

The purpose of this study was to explore effective ways for therapists to respond when clients ask questions during therapy sessions. Specifically, the researchers hypothesize that utilizing four guidelines for responding to client questions developed by Edelstein and Waehler (1. Receive the question respectfully, 2. Promote client curiosity, 3. Answer the question sufficiently, and 4. Explore possible underlying or idiosyncratic meanings of the question) is more effective in resulting in three desirable therapeutic outcomes (1. Clients explore material with greater depth, 2. Clients explore material with greater breadth, and 3. Client-therapist connectedness is enhanced) than either a response that solely utilizes psychoeducation, or a restatement of the client's question. Participants were assigned to one of three groups. The first group viewed a video in which the therapist responded to the client's question, "Will I get better?" by utilizing Edelstein and Waehler's four guidelines. The second group viewed a video in which the therapist responded to the client's question, "Will I get better?" by educating the client about rates of improvement in therapy based on research (psychoeducation). The third group viewed a video in which the therapist did not respond directly to the client's question, "Will I get better?" and instead, simply restated the client's question. Three measures that reflect the three desirable therapeutic outcomes outlined by Edelstein and Waehler, as well as a measure

of perceived counselor credibility were then completed by each participant for between-group comparison. The three desirable outcomes are viewed as factors that enhance the therapeutic process, and thus, can help individuals seeking therapy make greater strides in achieving their goals in therapy. Thus, this study may help to inform how therapists respond to client questions in ways that optimally enhance the therapeutic growth. If you would like to be informed about the results of this study, please call or e-mail Natalie Grandy at (810) 956-8242 or [nmg35@zips.uakron.edu](mailto:nmg35@zips.uakron.edu).

If you would like to learn more about the counseling process or desire counseling services for yourself, please contact one of the numbers listed below. Again, thank you for your participation in this study.

#### **Counseling Resources**

##### **The University of Akron Counseling Center**

Simmons Hall, Third Floor  
Fee paid out of student fees

**[330-972-7083](tel:330-972-7083)**

##### **Psychology Counseling Clinic**

CAS Building, Third Floor  
Free to students and public

**[330-972-6714](tel:330-972-6714)**

##### **Clinic for Individual and Family Counseling**

Chima Building, 2<sup>nd</sup> Floor  
Sliding fee based on income

**[330-972-6822](tel:330-972-6822)**

## Appendix M

## Observer Rating Form 1

1. How representative of an actual therapy session does this vignette appear to be?

1	2	3	4	5	6	7
Not at all representative of an actual therapy session						Extremely representative of an actual therapy session

## Appendix N

## Observer Rating Form 2

1. To what extent did the therapist receive the client's question ("Do you think I'll get better?") with respect?

1	2	3	4	5	6	7
The therapist received the client's question with no respect						The therapist received the client's question with the utmost respect

2. Did the therapist promote the client's curiosity about the her question ("Do you think I'll get better?")?

1	2	3	4	5	6	7
The therapist did not promote the client's curiosity at all						The therapist promoted the client's curiosity

3. Did the therapist answer the client's question ("Do you think I'll get better?") sufficiently to keep the client engaged?

1	2	3	4	5	6	7
The therapist did not answer the client's question at all						The therapist answered the client's question sufficiently

4. Did the therapist consider underlying or idiosyncratic meanings of the client's question ("Do you think I'll get better?")?

1	2	3	4	5	6	7
The therapist did not consider underlying or idiosyncratic meanings at all						The therapist considered underlying or idiosyncratic meanings

5. Did the therapist provide the client with psychoeducation in response to her question (“Do you think I’ll get better”)?

1

2

3

4

5

6

7

The therapist did not  
respond with any amount  
of psychoeducation

The therapist  
responded with  
psychoeducation to  
a very large extent

6. Did the therapist reflect the client’s question (“Do you think I’ll get better?”) back to her?

1

2

3

4

5

6

7

The therapist did not  
reflect the client’s  
question back to her at all

The therapist  
reflected the client’s  
question to a very  
large extent